

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06501

1. DECEDENT'S NAME (First, Middle, Last) Roscoe Vernon Wolverton ROSCOE WOLVERTON		2. DATE OF DEATH MONTH DAY YEAR 02 11 94		3. TIME OF DEATH 11:30A M
4. SOCIAL SECURITY NUMBER 579-09-0561	5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	7. DATE OF BIRTH (Month, Day, Year) July 12, 1912	8. BIRTHPLACE (State or Foreign Country) Virginia
9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's
RESIDENCE OF DECEDENT				
10a. STATE Maryland	10b. COUNTY Prince George's	10c. CITY, TOWN OR LOCATION College Park		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
10e. STREET AND NUMBER 8518 63rd Avenue		10f. ZIP CODE 20740		10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Brake Man		16b. KIND OF BUSINESS/INDUSTRY Pennsylvania Railroad
17. FATHER'S NAME (First, Middle, Last) Elmer Wolverton		18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude N/A		
19a. INFORMANT'S NAME (Type/Print) Katherine Wolverton		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8518 63rd Avenue College Park Maryland 20740		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 2/18		20c. LOCATION — City or Town, State Brentwood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kaiser Dutter</i> MO0907		22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc. 3401 Biadensburg Rd, Brentwood Md 20722		
23/ PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiogenic Shock</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>DIABETES MELLITUS</i> <i>Hypertension</i>				Approximate Interval Between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD.		29c. LICENSE NUMBER D20072		29d. DATE SIGNED (Month, Day, Year) February 12, 1994
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr Sudhakar Punija 3001 Hospital Drive Cheverly Md 20785				
31. DATE FILED (Month, Day, Year) FEB 15 1994		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06502

1. DECEDENT'S NAME (First, Middle, Last) <b>Mary Mildred Williams</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 9 1994</b>		3. TIME OF DEATH <b>5:00 A.M. M</b>							
4. SOCIAL SECURITY NUMBER <b>196 18 0271</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Mar. 30 1906</b>		8. BIRTHPLACE (State or Foreign Country) <b>Johnstown, Pa.</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>				9c. COUNTY OF DEATH <b>Anne Arundel</b>					
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Annapolis</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>3120 Port Way</b>				10f. ZIP CODE <b>21403</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Bookkeeper</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Business</b>									
17. FATHER'S NAME (First, Middle, Last) <b>William F. Clinger</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lydia Knipple</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Marlene Schneider</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3120 Port Way Annapolis Md. 21403</b>									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Richland Cemetery</b>		DATE		20c. LOCATION — City or Town, State <b>Johnstown, Pa.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert E. Ewing Pres</b>				22. NAME AND ADDRESS OF FACILITY <b>Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Bilateral Extensive Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Congestive Heart failure, recurrent,</b> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Herpes Zoster (face); Atrial fibrillation</b>								Approximate Interval Between Onset and Death <b>+ 10 Days</b> <b>years</b>					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <b>Peter F. VerKouw</b>		29c. LICENSE NUMBER <b>D11653</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/9/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PETER F. VERKOUW 1833 Ford Dr Annapolis MD 21401</b>								31. DATE FILED (Month, Day, Year) <b>FEB 15 1994</b>		32. REGISTRAR'S SIGNATURE <b>Sarah Davidson-Randall</b>			



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06503

1. DECEDENT'S NAME (First, Middle, Last) <b>ALFRED ANTHONY WARNER</b>			2. DATE OF DEATH MONTH <b>FEB</b> DAY <b>10</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>6:54 P</b>
4. SOCIAL SECURITY NUMBER <b>579-03-9731</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 26, 1918</b>
9a. FACILITY NAME (If not institution, give street and number) <b>Prince George's Hospital</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>Cheverely</b>		9c. COUNTY OF DEATH <b>Prince George's</b>
RESIDENCE OF DECEDENT					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Hyattsville</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			10e. STREET AND NUMBER <b>4409 75th Ave.</b>		
10f. ZIP CODE <b>20784</b>			10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>0</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Pressman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>G.P.O.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>James H. Warner</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ida M. Fletcher</b>		
19a. INFORMANT'S NAME (Type/Print) <b>James A. Warner</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8505 Madison St., New Carrollton, MD 20784</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery 2/15/94</b>		20c. LOCATION — City or Town, State <b>Brentwood</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>			22. NAME AND ADDRESS OF FACILITY <b>Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary artery disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>arteriosclerotic cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>chronic obstructive pulmonary disease</b> <b>diabetic mellitus</b>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Wynnevalle, MD</b>		29c. LICENSE NUMBER <b>D12879</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB 12, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ALFONSO VALLE M.D. 10701 TROFTON DR. LARGO, MD 20777</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 15 1994</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06504

1. DECEDENT'S NAME (First, Middle, Last) <b>KAREN R. WILLIAMS</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>6</b> YEAR <b>94</b>		3. TIME OF DEATH <b>3:40 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>577-92-0461</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>33</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-4-60</b>	
8. BIRTHPLACE (State or Foreign Country) <b>D.C.</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>LANHAM</b>		10. COUNTY OF DEATH <b>Prince George's</b>	
11. FACILITY NAME (If not institution, give street and number) <b>Doctor's Community Hospital</b>				12. RESIDENCE OF DECEDENT 10a. STATE <b>MD</b> 10b. COUNTY <b>Prince Georges</b> 10c. CITY, TOWN OR LOCATION <b>Mitchellville</b> 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13. STREET AND NUMBER <b>11503 BAYARD Drive</b> 10f. ZIP CODE <b>20716</b> 10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		15. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		17. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
18. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				19. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Tax Advisor</b>		20. KIND OF BUSINESS/INDUSTRY <b>Government</b>	
21. FATHER'S NAME (First, Middle, Last) <b>FRANK M. WILLIAMS SR</b>				22. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LORINE HAIRSTON</b>			
23. INFORMANT'S NAME (Type/Print) <b>FRANK M. WILLIAMS III</b>				24. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11503 Bayard Dr., Mitchellville, MD 20716</b>			
25. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		26. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>NORTHERN VIRGINIA 2-12-94</b>		27. LOCATION — City or Town, State <b>ARLINGTON, VA</b>		28. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Pamela M. Matar</b>	
29. NAME AND ADDRESS OF FACILITY <b>411 Kennedy St. N.W. Universal Mortuary WASHINGTON, D.C.</b>		30. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pulmonary Embolus</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Sickle Cell Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		31. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		32. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
33. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		34. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		35. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		36. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
37. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		38. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		39. TIME OF INJURY <b>M</b>		40. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
41. DESCRIBE HOW INJURY OCCURRED		42. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		43. LOCATION (Street and Number or Rural Route Number, City or Town, State)		44. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
45. SIGNATURE AND TITLE OF CERTIFIER <b>Paul A. DeVore, M.D., Deputy Medical Examiner</b>		46. LICENSE NUMBER <b>MD1852</b>		47. DATE SIGNED (Month, Day, Year) <b>2-6-94</b>		48. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PAUL A. DEVORE MD 4203 Queensbury Rd Hyattsville MD 20781</b>	
49. DATE FILED (Month, Day, Year) <b>FEB 14 1994</b>		50. REGISTRAR'S SIGNATURE <b>Gelia Davidson-Randall</b>					





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06505

1. DECEDENT'S NAME (First, Middle, Last) <b>RYAN McCALL WILLIAMS</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>11</b> YEAR <b>94</b>				3. TIME OF DEATH <b>11 28 PM</b>			
4. SOCIAL SECURITY NUMBER <b>212-19-6937</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>22</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 29, 1971</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>				9c. COUNTY OF DEATH <b>MONTGOMERY</b>			
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>2831 CALVERTON BOULEVARD</b>				10f. ZIP CODE <b>20904</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 6+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>STOCK CLERK</b>		16b. KIND OF BUSINESS/INDUSTRY <b>GIANT FOODS</b>							
17. FATHER'S NAME (First, Middle, Last) <b>FRED M. WILLIAMS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EVELYN PATRICIA REED</b>							
19a. INFORMANT'S NAME (Type/Print) <b>E. PATRICIA HAYDEN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2831 CALVERTON BOULEVARD SILVER SPRING, MD. 20904</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>FORT LINCOLN CEMETERY</b>		DATE <b>2/15</b>		20c. LOCATION — City or Town, State <b>BRENTWOOD, MARYLAND</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Francis J. Collins</i>				22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Seizure Disorder</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b>								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Paerber</i>						29c. LICENSE NUMBER <b>DO8546</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-11-94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John Paerber 8218 WISCONSIN AVE</b>											
31. DATE FILED (Month, Day, Year) <b>FEB 15 '94</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>							

5

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				94 06506					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) <u>Roger F. Whetzel</u>				2. DATE OF DEATH MONTH <u>Feb</u> DAY <u>8</u> YEAR <u>94</u>				3. TIME OF DEATH <u>10:50 AM</u>					
4. SOCIAL SECURITY NUMBER <u>214-28-4544</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>62</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Sept. 09, 1931</u>		8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>					
9a. FACILITY NAME (If not institution, give street and number) <u>12804 Eckmoor Road</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Silver Spring</u>				9c. COUNTY OF DEATH <u>Montgomery</u>					
10a. STATE <u>Maryland</u>				10b. COUNTY <u>Montgomery</u>		10c. CITY, TOWN OR LOCATION <u>Silver Spring</u>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER <u>12804 Eckmoor Road</u>				10f. ZIP CODE <u>20904</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10</u> College (1-4 or 5+) <u>College</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Postal Carrier</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Post Office</u>									
17. FATHER'S NAME (First, Middle, Last) <u>Casper Whetzel</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Ethel Howes</u>									
19a. INFORMANT'S NAME (Type/Print) <u>Vivian Whetzel</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>12804 Eckmoor Rd. Silver Spring, Maryland 20904</u>									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Union Cemetery</u>		DATE <u>2/12</u>		20c. LOCATION — City or Town, State <u>Burtonsville, Maryland</u>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>James Kent-Holland</u>				22. NAME AND ADDRESS OF FACILITY <u>Hines-Rinaldi Funeral Home</u> <u>11800 New Hampshire Avenue</u> <u>Silver Spring, Maryland 20904</u>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>arteriosclerotic heart disease</u>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.								Approximate interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <u>John Davidson-Randall</u>		29c. LICENSE NUMBER <u>D08546</u>		29d. DATE SIGNED (Month, Day, Year) <u>Feb-9-94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>John Davidson-Randall</u> <u>8218 Wisconsin Ave NW</u>													
31. DATE FILED (Month, Day, Year) <u>FEB 15 1994</u>				32. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06507

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM WAYNE WALKER</b>				2. DATE OF DEATH MONTH <b>FEB</b> DAY <b>10</b> YEAR <b>94</b>		3. TIME OF DEATH <b>0335 AM</b>				
4. SOCIAL SECURITY NUMBER <b>215-38-2929</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>54</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 8, 1939</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ROCKVILLE</b>			9c. COUNTY OF DEATH <b>MONTGOMERY</b>			
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>FREDERICK</b>		10c. CITY, TOWN OR LOCATION <b>FREDERICK</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>4103 ARABY CHURCH ROAD</b>				10f. ZIP CODE <b>21701</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>—</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HEAVY EQUIPMENT OPERATOR</b>		15b. KIND OF BUSINESS/INDUSTRY <b>EXCAVATING</b>				
17. FATHER'S NAME (First, Middle, Last) <b>CRITTENDEN WALKER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LENA LENHART</b>						
19a. INFORMANT'S NAME (Type/Print) <b>JANE MAY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS # 10</b>						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. OLIVET CEMETERY</b>			20c. LOCATION — City or Town, State <b>FREDERICK, MD.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Muriel H. Barber</i>				22. NAME AND ADDRESS OF FACILITY <b>MURIEL H. BARBER FUNERAL HOME 20882 LAYTONSVILLE, MD. 20882</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SUBDURAL HEMATOMAS</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>SUBDURAL HEMATOMAS</b> DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>6 DAYS</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ALCOHOLISM</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>2 4 94</b>		28b. TIME OF INJURY <b>0100 M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>FOUND IN STREET</b>		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>STREET</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>124 E DIAMOND AVE GAITHERSBURG</b>								
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Davidson-Randall</i>		29c. LICENSE NUMBER <b>D07099</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-10-94</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FRANCIS MAYLE 10215 FERNWOOD RD BETHESDA MD 20817 1106</b>										
31. DATE FILED (Month, Day, Year) <b>FEB 15 1994</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>								





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06508

1. DECEDENT'S NAME (First, Middle, Last) Estelle Richards Woodruff				2. DATE OF DEATH MONTH DAY YEAR February 9, 1994		3. TIME OF DEATH 6:00 A. M.	
4. SOCIAL SECURITY NUMBER 215-38-6211		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 12, 1908	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9. COUNTY OF DEATH Montgomery			
9a. FACILITY NAME (If not institution, give street and number) 6923 Clarendon Road, #321				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6923 Clarendon Road, #321				10f. ZIP CODE 20814		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Interior Decorator		16b. KIND OF BUSINESS/INDUSTRY Lord & Taylor			
17. FATHER'S NAME (First, Middle, Last) Joseph Melvin Richards				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude E. Gettingher			
19a. INFORMANT'S NAME (Type/Print) William L. May, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4217 Kenny Street, Beltsville, Maryland 20705			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. 2/12/94		20c. LOCATION — City or Town, State Bethesda, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michele P. Kutta</i> M00348				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave., Bethesda, Maryland 20814			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma Cecum DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinsons Disease Peripheral Vascular Disease							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Blaine Fitzgerald</i>				29c. LICENSE NUMBER D01948		29d. DATE SIGNED (Month, Day, Year) February 9, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Blaine Fitzgerald, M.D. 8218 Wisconsin Avenue, Bethesda, Maryland 20814-3107							
31. DATE FILED (Month, Day, Year) FEB 14 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.




1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06509

1. DECEDENT'S NAME (First, Middle, Last) <b>RUTH O. WILLIAMS</b>				2. DATE OF DEATH MONTH <b>FEB.</b> DAY <b>8,</b> YEAR <b>1994</b> <b>XX</b>		3. TIME OF DEATH <b>10:10 P M</b>	
4. SOCIAL SECURITY NUMBER <b>220 12 4179</b>		5. SEX <b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 10, 1910</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Indiana</b>				9a. FACILITY NAME (If not institution, give street and number) <b>809 QUINCE ORCHARD BLVD. #21</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>GAITHERSBURG</b>	
9c. COUNTY OF DEATH <b>MONTGOMERY</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>MONTGOMERY</b>	
10c. CITY, TOWN OR LOCATION <b>GAITHERSBURG</b>				10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>809 QUINCE ORCHARD BLVD. #21</b>	
10f. ZIP CODE <b>20878</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <b>XX</b> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SECRETARY S.D.A. GENERAL CONFERENCE</b>				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>ROBERT WILLIAMS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ESTHER GOOD</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DONNA CUMMINS LINDSEY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>909 DAVISAVE. TAKOMA PARK, MD 20912</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory 2/12/94 ALEXANDRIA, VA.</b>			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			
22. NAME AND ADDRESS OF FACILITY <b>TAKOMA FUNERAL HOME INC 245 CARROLL ST N.W. WASHINGTON, D.C. 20012</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>ventricular arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>hypertension</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>ischemic heart disease</b> DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>cerebrovascular disease</b>				24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>8</b> <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>			
28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 			
29c. LICENSE NUMBER <b>D19294</b>				29d. DATE SIGNED (Month, Day, Year) <b>February 9, 1994</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John R. Melnick, M.D., 911 Russell Ave., Gaithersburg, Maryland 20879-3266</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 14 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

State of Indiana  
1897

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06510

1. DECEDENT'S NAME (First, Middle, Last) HARRY I. WRIGHT				2. DATE OF DEATH MONTH DAY YEAR 2/4/94		3. TIME OF DEATH 4.15 AM M	
4. SOCIAL SECURITY NUMBER 240 40 3536		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 5, 1915	
9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH RIVERDALE		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION HYATTSVILLE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2208 AMHERST RD				10f. ZIP CODE 20783		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Orphaned		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant		16b. KIND OF BUSINESS/INDUSTRY Federal Government			
17. FATHER'S NAME (First, Middle, Last) NEWTON WRIGHT				18. MOTHER'S NAME (First, Middle, Maiden Surname) CORA SMITH			
19a. INFORMANT'S NAME (Type/Print) MARIKO S. WRIGHT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS 10e			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cem. 2/8/94		20c. LOCATION — City or Town, State Cheltenham, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Takoma Funeral Home 254 Carroll St N.W. Washington, D.C. 20012			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CEREBRAL INFARCTION</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>RESPIRATORY ARREST, PNEUMONIA</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER B01852		29d. DATE SIGNED (Month, Day, Year) 2-5-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul A. DeVare MD 4203 Queensbury Rd Hyattsville MD 20781							
31. DATE FILED (Month, Day, Year) FEB 08 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6, 7, 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 06511

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Hattie B. Williams				2. DATE OF DEATH MONTH 01 DAY 30 YEAR 1994		3. TIME OF DEATH 1:02 PM	
4. SOCIAL SECURITY NUMBER 218-24-6542		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-09-1931	
8. BIRTHPLACE (State or Foreign Country) Wash. DC				9a. FACILITY NAME (If not institution, give street and number) Greater Laurel Beltsville Hosp.		9b. CITY, TOWN OR LOCATION OF DEATH Laurel	
9c. COUNTY OF DEATH Prince George				10a. STATE Maryland		10b. COUNTY Prince Georges	
10c. CITY, TOWN OR LOCATION Beltsville				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 11407 Edmonston Road	
10f. ZIP CODE 20705				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 yrs				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Claims Adjuster		16b. KIND OF BUSINESS/INDUSTRY U.S. Civil Service	
17. FATHER'S NAME (First, Middle, Last) Warner Adams				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mazie Davis			
19a. INFORMANT'S NAME (Type/Print) Milton B. Williams (Husband)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11407 Edmonston Rd., Beltsville, MD 20705			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington Nat'l Cem. 2/14		20c. LOCATION — City or Town, State Arlington, VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiopulmonary Arrest</i> b. <i>Coronary Artery Disease</i> c. <i>Coronary Artery Disease</i> d. <i>Coronary Artery Disease</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death ~ hrs ~ hrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. Ford</i>			
29c. LICENSE NUMBER D-29097				29d. DATE SIGNED (Month, Day, Year) 1/31/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. Sood, M.D. 3060 Mitchellville Road, Bowie, MD							
31. DATE FILED (Month, Day, Year) FEB 14 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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Handwritten text, possibly a date or name.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06512

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <u>Joel NMI Williams</u>		2. DATE OF DEATH MONTH <u>2</u> DAY <u>14</u> YEAR <u>94</u>		3. TIME OF DEATH <u>1855</u> M
4. SOCIAL SECURITY NUMBER <u>579-58-1378</u>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <u>78</u> YRS.	7. DATE OF BIRTH (Month, Day, Year) <u>Aug. 2, 1915</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Mass.</u>		9a. FACILITY NAME (If not institution, give street and number) <u>Suburban Hospital</u>		
9b. CITY, TOWN OR LOCATION OF DEATH <u>Bethesda</u>		9c. COUNTY OF DEATH <u>Montgomery</u>		
10a. STATE <u>MD</u>		10b. COUNTY <u>Montgomery</u>		10c. CITY, TOWN OR LOCATION <u>Bethesda</u>
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>9020 Burdette Road</u>		
10f. ZIP CODE <u>20817</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>5+</u> College (1-4 or 5+) <u>5+</u>		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Statistician</u>		16b. KIND OF BUSINESS/INDUSTRY <u>U.S. Gov't.</u>		
17. FATHER'S NAME (First, Middle, Last) <u>Charles S. Williams</u>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Gussie Stanersky</u>		
19a. INFORMANT'S NAME (Type/Print) <u>Helen L. Williams</u>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>9020 Burdette Rd., Bethesda, MD 20817</u>		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>King David Memorial Gdns. 2/16</u>		20c. LOCATION — City or Town, State <u>Falls Church, VA</u>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Michael E. Nelson</u>		22. NAME AND ADDRESS OF FACILITY <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisconsin Ave, NW, Washington, DC 20016</u>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>sepsis syndrome</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>urinary tract infection</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>bladder cancer</u> DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>upper gastrointestinal bleed</u> <u>Alzheimer's disease</u>				
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>		29c. LICENSE NUMBER <u>233445</u>		29d. DATE SIGNED (Month, Day, Year) <u>2/15/94</u>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27, Type, Print) <u>809 Versailles Rd Rockville MD 20851</u>				
31. DATE FILED (Month, Day, Year) <u>FEB 16 1994</u>		32. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06513

1. DECEDENT'S NAME (First, Middle, Last) Yasuko Hosoda Young		2. DATE OF DEATH MONTH DAY YEAR February 12, 1994		3. TIME OF DEATH 1:20 P M	
4. SOCIAL SECURITY NUMBER 225-92-8225		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 49 YRS.	
7. DATE OF BIRTH (Month, Day, Year) Nov. 15, 1944		8. BIRTHPLACE (State or Foreign Country) Japan			
9a. FACILITY NAME (If not institution, give street and number) 10332 Bells Mill Terrace		9b. CITY, TOWN OR LOCATION OF DEATH Potomac		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Potomac	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 10332 Bells Mill Terrace		10f. ZIP CODE 20854	
10g. CITIZEN OF WHAT COUNTRY? Japan		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Japanese			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 5		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Legal Researcher		16b. KIND OF BUSINESS/INDUSTRY American Petroleum Institute	
17. FATHER'S NAME (First, Middle, Last) Yasuo Hosoda		18. MOTHER'S NAME (First, Middle, Maiden Surname) Namiyo Koike			
19a. INFORMANT'S NAME (Type/Print) John Lindsay Young		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore-Washington Crem 2-13		20c. LOCATION — City or Town, State Laurel, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ellen H. Rapp		22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Colon Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER 031703		29d. DATE SIGNED (Month, Day, Year) February 12, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen Vaccaro 33 6240 Montrose Rd Rockville MD 20852					
31. DATE FILED (Month, Day, Year) FEB 14 1994		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 06514

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PETER ANTONOPOULOS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>03 01 94</b>		3. TIME OF DEATH <b>7:45 a m</b>	
4. SOCIAL SECURITY NUMBER <b>195-30-8889</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>February 28, 1928</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Greece</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Greater Baltimore Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>	
9c. COUNTY OF DEATH <b>Balto.</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Balto.</b>	
10c. CITY, TOWN OR LOCATION <b>Timonium</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>116 Belfast Road</b>	
10f. ZIP CODE <b>21093</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Owner</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Restaurant</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Anthony Antonopoulos</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Paraskevi Tzoumi</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Maria Antonopoulos</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10e</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Demetrios Cemetery 3/4/94</b>		20c. LOCATION — City or Town, State <b>Parkville, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald C. Schaefer Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>1050 York Rd. 21204 Ruck Towson Funeral Home, Inc.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cardio-pulmonary arrest</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>hours</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide	
28a. DATE OF INJURY (Month, Day, Year)						28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Thomas F. Lansdown M.D.</b>						29c. LICENSE NUMBER <b>D43936</b>	
29d. DATE SIGNED (Month, Day, Year) <b>3/1/94</b>						30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Thomas F. Lansdown M.D. G.B.M.C. Towson, Md. 21204</b>	
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>							

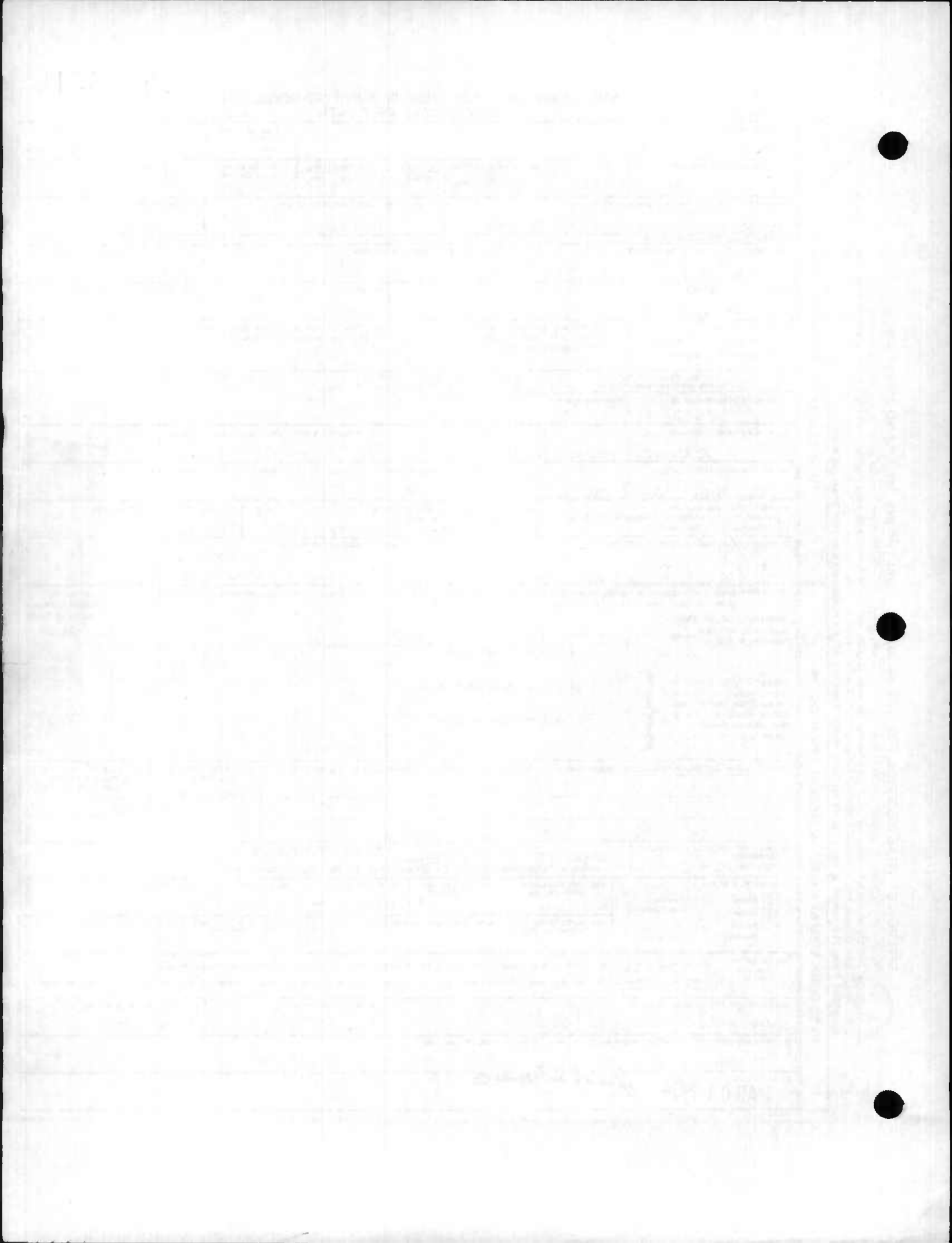
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94-1022-510

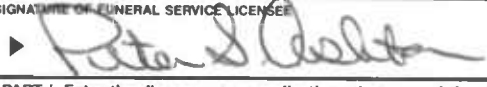
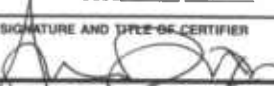
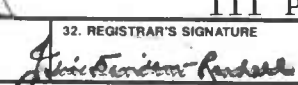
B.K.S

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-709 3/11/94 t.t

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06515

1. DECEDENT'S NAME (First, Middle, Last) <b>AMY T. AMORELLO</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAR 01 94</b>		3. TIME OF DEATH <b>7:48 P M</b>	
4. SOCIAL SECURITY NUMBER <b>013-72-0880</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>18 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>July 22, 1975</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>3400 NORTH CHARLES STREET</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Ma.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Pembroke, Ma</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>271 Valley Street.</b>				10f. ZIP CODE <b>02359</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Student</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Student</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Mark E. Amorello</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sandra J. Bruso</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mark E. Amorello</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>271 Valley Street Pembroke, Ma. 02359</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mayflower Cemetery 3-7-1994</b>		20c. LOCATION — City or Town, State <b>Duxbury Ma</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Sterling Ashton Funeral Home 736 Edmondson Ave., Baltimore, Md 21228</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>DRUG (DIPHENHYDRAMINE) INTOXICATION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>FOUND: 3-1-94</b>		28b. TIME OF INJURY <b>7:30 P M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT INGESTED DRUG</b>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>3400 N. CHARLES STREET RM. 103, BALTIMORE, MD.</b>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAR. 02, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06516

1. DECEDENT'S NAME (First, Middle, Last) <b>MARIE AYRES</b> <del>Marie</del> <del>AYERS</del>				2. DATE OF DEATH MONTH <b>3</b> - <b>2</b> - <b>94</b> DAY		3. TIME OF DEATH YEAR <b>4:15</b> P <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>215-18-6719</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 22, 1922</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Essex</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>839 Arncliffe Road</b>				10f. ZIP CODE <b>21221</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+) <b>Homemaker</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>George W. Blankenship</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edith Parker</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Thomas Ayres</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>839 Arncliffe Road Baltimore Md. 21221</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holly Hill Cemetery 3/5/94</b>		20c. LOCATION — City or Town, State <b>Baltimore MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>R. Terry Connelly</b>				22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Bowel Obstruction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Cancer endometrium metastatic</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Myo Thant</b>				29c. LICENSE NUMBER <b>D18487</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-2-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Myo Thant 9000 Franklin Square Dr. Baltimore, Maryland 21237</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <b>Julia Anderson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: All information on this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Registrar, Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is missed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

RECEIVED

RECEIVED

RECEIVED

ITEMS: 23 PART I, 27, 28a,b,d,e,f, PER MEO FILM G-709 3/17/94 t.t

94 06517

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES R. ALLEN</b>				2. DATE OF DEATH MONTH <b>FEB</b> DAY <b>26</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>PM</b>	
4. SOCIAL SECURITY NUMBER <b>214-80-3954</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>34</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 4, 1959</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>RANDALLTOWN</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>			
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Reisterstown</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER <b>22 Coliston Road</b>				10f. ZIP CODE <b>21136</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Landscaper</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>James H. Allen Jr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Audrey Bailey</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Connie M. Allen</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>22 Coliston Road Reisterstown, Md. 21136</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Crest Lawn Mem. Gardens 3-1-94</b>		20c. LOCATION — City or Town, State <b>Marriottsville, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>C. Brian Powell</b>				22. NAME AND ADDRESS OF FACILITY <b>11824 Reisterstown Road Eline Funeral Home Reisterstown, Md. 21136</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. NARCOTIC INTOXICATION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year) <b>UNKNOWN</b>		28b. TIME OF INJURY <b>UNKNOWN</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>UNKNOWN</b>	
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) <b>UNKNOWN</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>UNKNOWN</b>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Harold Meyhall</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB 27, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARYANN A KOREN 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <b>Julia [Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





MICHAEL BABIK

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06518

1. DECEDENT'S NAME (First, Middle, Last) <b>Michael Babik</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>28</b> YEAR <b>94</b>		3. TIME OF DEATH <b>12:00 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>135-74-1033</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>32</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>03-07-61</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HOWARD COUNTY GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>COLUMBIA</b>		9c. COUNTY OF DEATH <b>HOWARD</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>HOWARD</b>		10c. CITY, TOWN OR LOCATION <b>JESSUP</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7277 CEDAR AVENUE</b>				10f. ZIP CODE <b>20794</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>GLASS CUTTER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CONSTRUCTION</b>	
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE BABIK</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>PAULINE ISSA</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CHERYL ANNE BABIK (WIFE)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7277 CEDAR AVENUE JESSUP, MARYLAND 20794</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MEADOWRIDGE CEMETERY 03/03/94</b>		20c. LOCATION — City or Town, State <b>DORSEY, MARYLAND</b>		22. NAME AND ADDRESS OF FACILITY <b>LEROY M &amp; RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>LEROY M &amp; RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC ARREST</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>AORTIC VALVE DISEASE-</b>							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Valve Replacement Surgery Cardiomyopathy due to aortic valve disease</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Berand</i>				29c. LICENSE NUMBER <b>D26287</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/1/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Michael BERAND 7305 BALTIMORE AVE 107 College Park</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06519

1. DECEDENT'S NAME (First, Middle, Last) <b>BERNARD CALVIN BIAS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 28, 1994</b>		3. TIME OF DEATH <b>8:04 P. M</b>	
4. SOCIAL SECURITY NUMBER <b>219-03-3506</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 12, 1922</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Good Samaritan Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>2000 Taylor Ave.</b>		10f. ZIP CODE <b>21234</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerk</b>	
15a. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				15b. KIND OF BUSINESS/INDUSTRY <b>U.S. Post Office</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerk</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Calvin Bias</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Grace Wallace</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Lois K. Bias</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10a - #10e</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Mem. Park 3-3-94</b>		20c. LOCATION — City or Town, State <b>Arbutus, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck Inc. 5305 Harford Rd., Balto Md 21214</b>			
23. PART I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute myocardial infarction</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>ASVD</b> c. <b>Hypertension</b> d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PARKIN SON'S LIVER</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the base of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D17728</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/1/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ba Yin Oung, M.D. 8022 Belair Road, Balto. Md.</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certifies that the death certificate was completed and signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, or removal.  
IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06520

1. DECEDENT'S NAME (First, Middle, Last) ROBERT BRYAN BELL				2. DATE OF DEATH MONTH DAY YEAR FEB. 27, 1994		3. TIME OF DEATH 12:50 A M	
4. SOCIAL SECURITY NUMBER 214-88-1100		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 31 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG. 2, 1962	
9a. FACILITY NAME (If not institution, give street and number) ROOM #147-BOSTON INN				9b. CITY, TOWN OR LOCATION OF DEATH Westminster WESTMINISTER		9c. COUNTY OF DEATH CARROLL	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION GLEN BURNIE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6 GLEN CIRCLE				10f. ZIP CODE 21060		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) NONE				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CONSTRUCTION		16b. KIND OF BUSINESS/INDUSTRY SOVEREIGN CONTRACTING, INC.	
17. FATHER'S NAME (First, Middle, Last) EVERETT W. BELL, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSALIE J. JOHNSON			
19a. INFORMANT'S NAME (Type/Print) MR. EVERETT W. BELL, SR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 GLEN CIRCLE, GLEN BURNIE, MARYLAND 21060			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILLTOP SERVICE, INC. 1994		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. Morgan Hopkins</i>				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Intoxicated gunshot wound of head</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) #147-BOSTON INN					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) FEB. 26, 1994		28b. TIME OF INJURY 12:01 A		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) MOTEL-BOSTON INN		28e. DESCRIBE HOW INJURY OCCURRED SUBJECT SHOT SELF			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) WESTMINISTER-CARROLL MARYLAND					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King, M.D.</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) ▶	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING							
31. DATE FILED (Month, Day, Year) MAR 04 1994				32. REGISTRAR'S SIGNATURE <i>John Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06521

1. DECEDENT'S NAME (First, Middle, Last) <b>Wilbur Oran Baisley</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 4, 1994</b>		3. TIME OF DEATH M <b>7A</b>	
4. SOCIAL SECURITY NUMBER <b>100 09 9030</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9/4/08</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>3702 Lochearn Drive</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3702 Lochearn Drive</b>				10f. ZIP CODE <b>21207</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWI</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) <b>Laundry Self employed</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Dry Cleaning</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Wilbur Oran Baisley</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>May Conklin</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Patricia A. Garrison</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3702 Lochearn Dr. Baltimore, Md. 21207</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lake View Mem. Park 3/7/94</b>		20c. LOCATION — City or Town, State <b>Sykesville, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Harry W. Haight</b>				22. NAME AND ADDRESS OF FACILITY <b>Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Atherosclerotic Coronary Vascular Disease</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Robert L. Morris, MD</b>				29c. LICENSE NUMBER <b>032882</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/7/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Robert L. Morris 117 Business Center Drive Reisterstown, MD</b>							
31. DATE FILED (Month, Day, Year) <b>3/4/94</b>				32. REGISTRAR'S SIGNATURE <b>John H. Haight</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94-1044-510

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06522

1. DECEDENT'S NAME (First, Middle, Last) <b>AKA Constance M. Bednarski</b> <b>CONSTANCE M. HAMPTON</b>		2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 02 1994</b>		3. TIME OF DEATH <b>4:40 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>214 18 9454</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 27 1922</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>3528 CLIFTMONT AVE</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b></b>	
RESIDENCE OF DECEDENT					
10a. STATE <b>MD</b>		10b. COUNTY <b>-</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>3528 Clifmont Ave.</b>		10f. ZIP CODE <b>21213</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>housewife</b>		17. KIND OF BUSINESS/INDUSTRY <b>Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Michael E. Kolakowski, Sr.</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ida Zwolinski</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Michael E. Kolakowski, Jr.</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>171 Topeg Dr. Severna Pk., MD 21146</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place) <b>Baltimore National Cemetery 3/7/94</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dennis J. Chute</i>		22. NAME AND ADDRESS OF FACILITY <b>Bruzdzinski Funeral Home PA 1407 Eastern Ave. Baltimore, MD 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Atherosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF):			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):			
		c. DUE TO (OR AS A CONSEQUENCE OF):			
		d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute</i>		29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 03, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>		32. REGISTRAR'S SIGNATURE <i>John D. Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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94 06523

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES E. BRYAN</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>01</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>10-30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>220 09 6618</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>07/24/1916</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>GRVINGTON KNOLL NURSING CENT.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>Maryland</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Ellicott City</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>3167 "C" West Springs Dr.</b>				10f. ZIP CODE <b>21043</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Equipment Operator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>			
17. FATHER'S NAME (First, Middle, Last) <b>James E. Bryan, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lilly May Millstead</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Grave Horner</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3700 "C" White Pine Rd. Balto., MD 21220</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Carmel Meth. Ch. Cemetery</b>		20c. LOCATION — City or Town, State <b>3/4/94 Sunshine, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Brudzinski Funeral Home PA 1407 Eastern Ave. Baltimore, MD 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>UROSEPSIS</b>							<b>15 days</b>
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>NEUROGENIC BLADDER</b>							<b>3 yrs</b>
c. <b>DEMENTIA</b>							<b>6 yrs</b>
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Infected bilateral hip decubiti</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Amatun N Naeem</i>				29c. LICENSE NUMBER <b>D 15503</b>		29d. DATE SIGNED (Month, Day, Year) <b>03/02/1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>AMATUN N NAEEM, 501 DOLPHIN STREET, BALTO, MD 21217</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Bellevue City

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SI043 "0" West Springs St.

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Connection

Equipment Operator

10/1 May 10/1/54

James E. Ryan, Sr.

1000 "0" West Springs St. Bellevue, WA 98004

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06524

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles Edward Boswell</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB 25, 1994</b>		3. TIME OF DEATH <b>11:35 P M</b>					
4. SOCIAL SECURITY NUMBER <b>213-01-2951</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>04/15/14</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Summit Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Catonsville</b>			9c. COUNTY OF DEATH <b>Baltimore</b>				
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Catonsville</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10a. STREET AND NUMBER <b>Summit Nursing Home 98 Smithwood Ave.</b>				10f. ZIP CODE <b>21228</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clock Repair</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Clock Shop</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Arthur Boswell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Amelia Brooks</b>							
19a. INFORMANT'S NAME (Type/Print) <b>E. Viola King</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>108 Amanda Avenue Hanover, PA 17331</b>							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 02/28 Baltimore, MD</b>		20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>George E. MacNabb</b>				22. NAME AND ADDRESS OF FACILITY <b>Cremation Society of Md., Inc. 299 Frederick Rd. Balto., MD 21228</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>John W. White M.D.</b>				29c. LICENSE NUMBER <b>123365</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/28/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>299 Frederick Rd. Balt., Md. 21228</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <b>John W. White</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Karen M. Bariga

VOID

94-06525

See

94-10522





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE		94 06526	
CERTIFICATE OF DEATH		REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) WALTER HENRY BADE		2. DATE OF DEATH MONTH DAY YEAR March 2, 1994		3. TIME OF DEATH 6:30 a m	
4. SOCIAL SECURITY NUMBER 085 07 5295		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.	
7. DATE OF BIRTH (Month, Day, Year) 9-20-07		8. BIRTHPLACE (State or Foreign Country) New York			
9a. FACILITY NAME (If not Institution, give street and number) Doctors Community Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Lanham		9c. COUNTY OF DEATH Prince George's	
10a. STATE MD		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Greenbelt	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 7010 Greenbelt Rd		10f. ZIP CODE 20770	
10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 + College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Engineer		16b. KIND OF BUSINESS/INDUSTRY Elevators	
17. FATHER'S NAME (First, Middle, Last) Johannes Bade		18. MOTHER'S NAME (First, Middle, Maiden Surname) Frieda Munder			
19a. INFORMANT'S NAME (Type/Print) Edith Davis		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6913 Darthmuth Ave, CollegePk, MD 20740			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir		22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiopulmonary Arrest</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Acute myocardial infarction</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Congestive Heart Failure</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>Coronary Heart Disease</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		Approximate Interval Between Onset and Death 2 days 2 days years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Sick Sinus syndrome, permanent pacemaker,</u> <u>Intermittent Atrial fibrillation, Abdominal Aneurysm</u> <u>Diverticular Disease of Colon, Anemia</u>		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Chin Guan Hsu, M.D.		29c. LICENSE NUMBER D05424	
29d. DATE SIGNED (Month, Day, Year) 3/2/94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Chin Guan Hsu, M.D. 6419 Baltimore Avenue, Riverdale, MD 20737			
31. DATE FILED (Month, Day, Year) MAR 04 1994		32. REGISTRAR'S SIGNATURE James M. ...			



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06527

1. DECEDENT'S NAME (First, Middle, Last) <i>Mary Gladys Chilcote</i>				2. DATE OF DEATH MONTH DAY YEAR <i>February 26, 1994</i>				3. TIME OF DEATH HOUR MIN. <i>9:45 P</i>			
4. SOCIAL SECURITY NUMBER <i>213-26-4855</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>63</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>2-24-1931</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>7864 St. Claire Lane</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Dundalk</i>				9c. COUNTY OF DEATH <i>Baltimore</i>			
RESIDENCE OF DECEDENT											
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Dundalk</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <i>7864 St. Claire Lane</i>				10f. ZIP CODE <i>21222</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>8th Grade</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i>			16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>				
17. FATHER'S NAME (First, Middle, Last) <i>Melvin Koontz</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Kane</i>							
19a. INFORMANT'S NAME (Type/Print) <i>Mr. William A. Chilcote</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7864 St. Claire Lane Dundalk, Maryland 21222</i>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Meadowridge Mem. Park 3/3/94</i>			20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Doreen E. Reed</i>				22. NAME AND ADDRESS OF FACILITY <i>Dudd-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory Failure from Carcinoma of Lungs</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>With Metastatic Lesions to Bone</i> <i>Brown &amp; Liver</i>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>RT Hip Fracture</i>										Approximate Interval Between Onset and Death	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <i>2/16/94</i>		28b. TIME OF INJURY <i>HA M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <i>Fell in Bathroom</i>	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>At Home</i>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>7864 St. Claire Lane - Dundalk</i>					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles F. O'Donnell MD</i>				29c. LICENSE NUMBER <i>D-09383</i>		29d. DATE SIGNED (Month, Day, Year) <i>2-28-94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Charles F. O'Donnell MD - 408 Harbor House - 111 Hamlet Hill Rd</i>											
31. DATE FILED (Month, Day, Year) <i>MAR 04 1994</i>				32. REGISTRAR'S SIGNATURE <i>John Sanderson-Russell</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06528

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARGARET ISABELLE COVINGTON</b>				2. DATE OF DEATH MONTH <b>FEBRUARY</b> DAY <b>28</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>120 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>216-32-2399</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 28, 1915</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not Institution, give street and number) <b>Good Samaritan Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Towson</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>20 Dunvale Road Apt. 207</b>		10f. ZIP CODE <b>21204</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+) <b>Homemaker</b>	
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>				17. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Benjamin Denton</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Roberta Lusby</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Robert M. Covington</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>530 West Lane, Belair, Md. 21015</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parkwood Cemetery 3-3-94</b>		20c. LOCATION — City or Town, State <b>Balto. Co., Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ernest L. Feist III</b>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck, Inc. 5305 Harford Rd., Baltimore, Md. 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>LEFT THIGH DEEP VENOUS THROMBOSIS</b>							
b. <b>RIGHT MIDDLE LOBE PULMONARY EMBOLUS</b>							
c. <b>URINARY TRACT INFECTION</b>							
d. <b>SCIATICA (SEVERE LOW BACK PAIN)</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>URINARY TRACT INFECTION</b> <b>SCIATICA (SEVERE LOW BACK PAIN)</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>MP</b>				29c. LICENSE NUMBER <b>P-07608</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEBRUARY 28<sup>TH</sup> 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JAMES APPIAH-PIPPIN, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD BALTIMORE MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <b>Julia Sanders-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DHMH-18 Rev 1/89



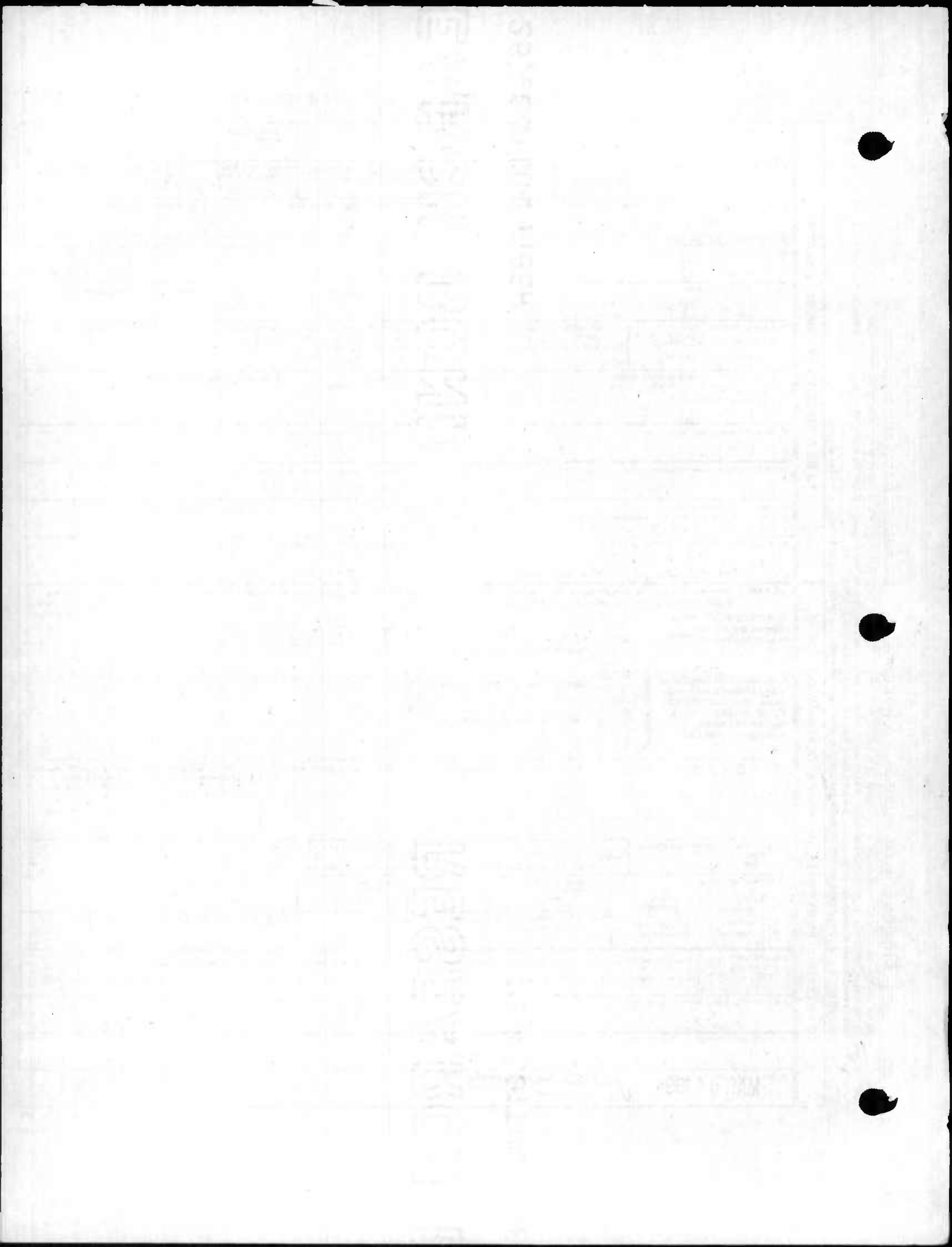


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				94 06530	
CERTIFICATE OF DEATH				REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last) Arthur R. Creigler				2. DATE OF DEATH MONTH 2 DAY 28 YEAR 1994				3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 217-05-7413		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
9a. FACILITY NAME (If not institution, give street and number) 517 Allendale Street				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH D.C.	
10a. STATE Md				10b. COUNTY				10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 517 Allendale Street				10f. ZIP CODE 21229	
10g. CITIZEN OF WHAT COUNTRY? U S A				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12th College (1-4 or 5+) College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Typesetter				16b. KIND OF BUSINESS/INDUSTRY				17. FATHER'S NAME (First, Middle, Last) Unknown	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Theresa				19a. INFORMANT'S NAME (Type/Print) Catherine R. Creigler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 517 Allendale Street Baltimore, Md 21229	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park 3594				20c. LOCATION — City or Town, State Arbutus, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Gladys Wynn				22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. COLON CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Richard L. Williams				29c. LICENSE NUMBER D29071	
29d. DATE SIGNED (Month, Day, Year) ▶ 3-4-94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KRISHNAN, MD 821 N. EUTAW ST #305 BALTIMORE MD 21201				31. DATE FILED (Month, Day, Year) MAR 04 1994	



Item# 1,10e,10c,10f Per F.H. Film# G-709 03/04/94 R.M.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06531

1. DECEDENT'S NAME (First, Middle, Last) <u>Martin Joseph Connor</u>				2. DATE OF DEATH MONTH <u>March</u> DAY <u>1</u> YEAR <u>1994</u>		3. TIME OF DEATH <u>1:45 AM</u>	
4. SOCIAL SECURITY NUMBER <u>212-07-9364</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>76</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>10 27 1917</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Mercy Medical Center</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		9c. COUNTY OF DEATH <u>Maryland</u>	
10a. STATE <u>MD</u>		10b. COUNTY <u>Baltimore</u>		10c. CITY, TOWN OR LOCATION <u>Towson</u>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>6501 Loch Hill Court</u> <u>611 S. Charles St.</u>				10f. ZIP CODE <u>21239</u> <u>21230</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>WW II</u>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10th grade</u> College (1-4 or 5+) <u></u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Film Executive</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Frank H. Durkee Enterprises</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Martin P. Connor</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Clara Ehrhart</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Sallyann T. Wargo</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6501 Loch Hill Court Baltimore, MD 21239</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Parkwood Cemetery</u>		DATE <u>3/3/94</u>		20c. LOCATION — City or Town, State <u>Baltimore, MD</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>Johnson Funeral Home</u> <u>8521 Loch Raven Blvd. Towson, MD 21286</u>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Sepsis</u> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Pneumonia</u> <u>Cardiac Arrest</u> <u>Hepatitis</u>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <u>3/1/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <u>MAR 04 1994</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THIS HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DMMH-16 Rev 1/89



94 06533

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES CONTEE</b>				2. DATE OF DEATH <b>2-25-94</b> MONTH DAY YEAR		3. TIME OF DEATH <b>4 A</b> M	
4. SOCIAL SECURITY NUMBER <b>220 28 6459</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>60</b> YRS.		7. DATE OF BIRTH <b>9-13-33</b> (Month, Day, Year)	
9a. FACILITY NAME (If not institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CLINTON</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George</b>		10c. CITY, TOWN OR LOCATION <b>Clinton</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Wellington Manor N/Hm 9211 Stewart La</b>				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>No</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		15b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>in state removal</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir</b>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board 655W. Baltimore St, Balto., MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Advanced human immunodeficiency viral infect.</b> a. DUE TO (OR AS A CONSEQUENCE OF): <b>Dementia</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>Pneumocystis infect.</b> c. DUE TO (OR AS A CONSEQUENCE OF): <b>Cachexia</b> d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval between Onset and Death <b>1 year</b> <b>1 year</b> <b>2 month</b> <b>4 month</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>K. Danack MD</b>				29c. LICENSE NUMBER <b>D25640</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/28/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>1328 South Ave SE Wash DC 20032</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <b>June Carson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06534

1. DECEDENT'S NAME (First, Middle, Last) <b>GERTRUDE ELIZABETH DRIESEN</b>				2. DATE OF DEATH MONTH <b>FEB.</b> DAY <b>28,</b> YEAR <b>1994</b>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <b>214-20-3169</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 15, 1915</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>AUGSBURG LUTHERAN HOME</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		8c. COUNTY OF DEATH <b>BALTIMORE</b>	
9a. STATE <b>MARYLAND</b>				9b. COUNTY <b>BALTIMORE</b>		9c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10a. STREET AND NUMBER <b>6501 HILLTOP AVENUE</b>				10f. ZIP CODE <b>21206</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ELEVATOR OPERATOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BALTO. GAS &amp; ELECTRIC</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM N. PITMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY HLADKY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARVIN R. DRIESEN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6501 HILLTOP AVENUE BALTIMORE, MD. 21206</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MORELAND MEMORIAL</b>		DATE <b>3/3/94</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Dolan</i> <b>JOHN E. DOLAN</b>				22. NAME AND ADDRESS OF FACILITY <b>LEONARD J. RUCK INC.</b> <b>5305 HARFORD ROAD BALTIMORE, DM. 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Respiratory failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>CA - Lung</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Congestive Heart failure</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>COPD</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary artery dx</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M Khan</i> <b>MD</b>				29c. LICENSE NUMBER <b>025391</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/2/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. MOHAMMED KHAN 5601 LOCH RAVEN BLVD. BALTIMORE, MD. 21239</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <i>John D. Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

6



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06535

1. DECEDENT'S NAME (First, Middle, Last) GRACE MAY DANIELS				2. DATE OF DEATH MONTH 02 DAY 28 YEAR 94		3. TIME OF DEATH 08:45 PM	
4. SOCIAL SECURITY NUMBER 213-64-2417		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 4, 1907	
8. BIRTHPLACE (State or Foreign Country) MARYLAND		9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH A.A. COUNTY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION GLEN BURNIE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6 IVY LANE				10f. ZIP CODE 21060		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 10 College (1-4 or 5+) NONE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) HOWARD E. BOYER				18. MOTHER'S NAME (First, Middle, Maiden Surname) ESTELLE LOWMAN			
19a. INFORMANT'S NAME (Type/Print) LEROY W. BOYER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 844 GENERALS HIGHWAY, MILLERSVILLE, MARYLAND 21108			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK 3/94		20c. LOCATION — City or Town, State GLEN BURNIE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jeff Nelson Zumbun				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Stroke DUE TO (OR AS A CONSEQUENCE OF): b. Pericarditis DUE TO (OR AS A CONSEQUENCE OF): c. Aortic Aneurysm Rupture DUE TO (OR AS A CONSEQUENCE OF): d. Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic Atherosclerotic Cardiovascular Disease							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Robert B. Kroopnick				29c. LICENSE NUMBER H17753		29d. DATE SIGNED (Month, Day, Year) 2/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT B. KROOPNICK, M.D./795 AQUAHART ROAD, #203/GLEN BURNIE, MARYLAND 21061							
31. DATE FILED (Month, Day, Year) MAR 04 1994		32. REGISTRAR'S SIGNATURE Julia Sanders-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO

PHYSICS DEPARTMENT

PHYSICS DEPARTMENT

PHYSICS DEPARTMENT

RECEIVED

1950

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06536

1. DECEDENT'S NAME (First, Middle, Last) <b>Mary A. DeHaven</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>1</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>10:30p M</b>	
4. SOCIAL SECURITY NUMBER <b>168-50-8778</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 09, 1902</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9. COUNTY OF DEATH <b>Anne Arundel</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>3721 Nile Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Davidsonville</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Davidsonville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3721 Nile Road</b>				10f. ZIP CODE <b>21035</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Homemaker</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Lawrence Slowik</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Murdock</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Linda Young</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8522 60th Ave. College Park, MD 20740-2652</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Calvary Mausoleum</b>		DATE		20c. LOCATION — City or Town, State <b>Altoona, PA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Complete stroke</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>Cerebral arteriosclerosis</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D13339</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>TSUNIE CHANCHIEN, M.D., P.A. 8824 CUNNINGHAM DRIVE HEIGHTS, MD. 20740</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06537

1. DECEDENT'S NAME (First, Middle, Last) LORETTA M. DeCOSMO				2. DATE OF DEATH MONTH 3 - DAY 1 - YEAR 94				3. TIME OF DEATH M							
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-18-34		8. BIRTHPLACE (State or Foreign Country) MARYLAND							
9a. FACILITY NAME (If not institution, give street and number) 7014 GOUGH STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH							
10a. STATE MARYLAND				10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE									
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 7014 GOUGH STREET		10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY									
17. FATHER'S NAME (First, Middle, Last) FRANK JAKOWSKI				18. MOTHER'S NAME (First, Middle, Maiden Surname) MAMMIE FILIPIAK											
19a. INFORMANT'S NAME (Type/Print) MR. GERALD DeCOSMO				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7014 GOUGH STREET BALTO. MD. 21224											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HOLY ROSARY CEMETERY		DATE 3-5		20c. LOCATION — City or Town, State BALTO. CO. MD.									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Chuck Jakowski</i>				22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVENUE BALTO. MD. 21222											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic Colon Carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul A. Hall</i>		29c. LICENSE NUMBER D2635		29d. DATE SIGNED (Month, Day, Year) 3/5/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
31. DATE FILED (Month, Day, Year) MAR 04 1994				32. REGISTRAR'S SIGNATURE <i>John Andrew Rudek</i>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





94 06538

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Nettie C. Emery</b>				2. DATE OF DEATH MONTH <b>2</b> - DAY <b>25</b> - YEAR <b>1994</b>				3. TIME OF DEATH <b>2:00 A</b> M	
4. SOCIAL SECURITY NUMBER <b>217-12-8048</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>83</b> YRS.	IF UNDER 1 YEAR MONTHS <b>2</b>	IF UNDER 24 HRS. DAYS <b>2</b>	HOURS <b>2</b>	MIN. <b>00</b>	7. DATE OF BIRTH (Month, Day, Year) <b>7-29-1910</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Lorien Frankford Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Md.</b>				10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>428 Nollmeyer Road</b>	
10f. ZIP CODE <b>21220</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine Hornsby</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Eugene Emery</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>428 Nollmeyer Rd., Baltimore, Md. 21220</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery 2-28-94 Balto., Md.</b>				20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bradley Ashton</b>				22. NAME AND ADDRESS OF FACILITY <b>Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd., Balto., Md.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Ischemic Heart Disease</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>Severe COPD Oxygen Brn - Cerebral</b>				Approximate Interval Between Onset and Death <b>yes</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Wm. C. R. P. II</b>				29c. LICENSE NUMBER <b>008357</b>	
29d. DATE SIGNED (Month, Day, Year) <b>3/4/94</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Patricia K. P. II</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

94 06539

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

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TO THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE		94 06540	
CERTIFICATE OF DEATH		REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <b>Alfred E. Fowler</b>		2. DATE OF DEATH MONTH <b>2</b> DAY <b>28</b> YEAR <b>94</b>		3. TIME OF DEATH <b>9:20 P M</b>	
4. SOCIAL SECURITY NUMBER <b>578-36-3991</b>	5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>64</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>3-5-1929</b>	8. BIRTHPLACE (State or Foreign Country) <b>DC</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>University of Maryland</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>MD</b>	
RESIDENCE OF DECEDENT		10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Millersville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>602 Millwright CT APT-13</b>		10f. ZIP CODE <b>21108</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>KOREAN</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SELF EMPLOYED OWNER</b>	
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM S. FOWLER</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EMILY GOODE</b>		19. KIND OF BUSINESS/INDUSTRY <b>CLOTHING SALES</b>	
19a. INFORMANT'S NAME (Type/Print) <b>BETH A. DILLARD</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8226 QUARTERFIELD RD-SEVERN, MD. 21144</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>OAKLAWN CEMETERY</b> DATE <b>3/4</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Larry L. Kaufman</b>		22. NAME AND ADDRESS OF FACILITY <b>RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Multi-Organ Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		Approximate Interval Between Onset and Death <b>5 days</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary artery Disease</b>		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>N/A</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>J. Amy Yan MD</b>		29c. LICENSE NUMBER <b>D-39718</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-28-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. Amy Yan MD</b>		<b>BALTIMORE, MD. 21201 UNIVERSITY HOSPITAL-22S. GREENE ST</b>			
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>			

RECEIVED FROM

RECEIVED FROM

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06541

1. DECEDENT'S NAME (First, Middle, Last) SAM FEIGENBAUM				2. DATE OF DEATH MONTH DAY YEAR February 26, 1994		3. TIME OF DEATH 2:20 P. M.	
4. SOCIAL SECURITY NUMBER 121-03-1796		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 95 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr. 20, 1899	
9a. FACILITY NAME (If not institution, give street and number) Hebrew Home of Greater Washington		9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery			
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 2612 Elnora Street			
10f. ZIP CODE 20902				10g. CITIZEN OF WHAT COUNTRY? U. S. A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Merchant		16b. KIND OF BUSINESS/INDUSTRY Dry Cleaning			
17. FATHER'S NAME (First, Middle, Last) Morris Feigenbaum				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ester Libe			
19a. INFORMANT'S NAME (Type/Print) Mildred M. Moon				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2612 Elnora Street, Silver Spring, Maryland 20902			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Lebanon Cemetery 3/1/94		20c. LOCATION — City or Town, State Adelphi, Maryland		20d. DATE 3/1/94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald C. Stottmeyer				22. NAME AND ADDRESS OF FACILITY STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D.C.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF): Auto Arterial Obstruction of Leg							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dermatitis Pernicious Anemia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Paul Kretzing MD				29c. LICENSE NUMBER N21435		29d. DATE SIGNED (Month, Day, Year) 2/27/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Kretzing MD, 2101 Medical Park Dr Silver Spring 20902							
31. DATE OF DEATH (Month, Day, Year) MAR 04 1994							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 06542

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Vincent GRAFF</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>28</b> YEAR <b>94</b>		3. TIME OF DEATH <b>9:35 P M</b>	
4. SOCIAL SECURITY NUMBER <b>213 32 2314</b>		5. SEX <b>1004 2 F</b>	6. AGE (In yrs. last birthday) <b>58</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>July 5, 1935</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Essex</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>9 Nerbay Road</b>				10f. ZIP CODE <b>21221</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Navy</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Factory Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Soap Mfg. Co. Lever Brothers Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Graff</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Helene Nowlett</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9 Nerbay Road Baltimore, Maryland 21221</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holy Rosary Cemetery 3/4/94</b>		20c. LOCATION — City or Town, State <b>Baltimore County, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Bruzdzinski Funeral Home PA 1407 Eastern Ave. Baltimore, Md. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic renal cell carcinoma</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>2-28-94</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Ronald Attanasio MD</b>				29c. LICENSE NUMBER <b>D-28097</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-1-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>1012 OLD NORTH Point Rd. Balt., Md. 21224</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

July 5, 1955 Maryland

25

XX

115 25 25

Baltimore

Franklin Square Hospital

XX

XXXX

Baltimore

Maryland

USA

1955

9 North Road

X

Navy

X

White

Long Mt. Co.

Lever Brothers Co.

Factory Worker

12

John

John Craft

9 North Road Baltimore, Maryland 2121

John Craft

John Rosary Cemetery 3/4/54 Baltimore County, Md.

X

Franklin Square Home PA

1007 Western Ave. Baltimore, Md. 2121

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 94 06543

1. DECEDENT'S NAME (First, Middle, Last) <b>Earlie M. Hall</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>27</b> YEAR <b>94</b>		3. TIME OF DEATH <b>1447</b> M	
4. SOCIAL SECURITY NUMBER <b>219-18-1739</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>07-15-1922</b>	
8. FACILITY NAME (If not institution, give street and number) <b>Northwest Hospital Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Randallstown</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Carroll</b>		10c. CITY, TOWN OR LOCATION <b>Westminster</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1735 Bollinger Road</b>				10f. ZIP CODE <b>21157</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Army - W.W. II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>-12-</b> College (1-4 or 5+) <b>-0-</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Maintenance Supervisor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>National Circuit Co.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>S. Grover Hall</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maggie Belle Wright</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Naomi S. Hall</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1735 Bollinger Rd. - Westminster, Md. - 21157</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Evergreen Mem. Gardens</b>		DATE <b>3/3/94</b>		20c. LOCATION — City or Town, State <b>Finksburg, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Eline Funeral Home</b> <b>11824 Reisterstown Road</b> <b>Reisterstown, Md. 21136</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Respiratory failure - pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>S/P D pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>(R) pneumonia / TRUS</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Cong LC</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> <b>Dr. Hsink</b>				29c. LICENSE NUMBER <b>H43974</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/27/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Hsink - Northwest Hospital Center - Randallstown, Maryland 21133</b>							
31. DATE SIGNED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



REG. NO. \_\_\_\_\_

DMMH-16 Rev 1/89

1

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be returned within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO THE HOSPITAL-OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \_\_\_\_\_ hours after death. Page 6 may be retained by the hospital or attending physician. \_\_\_\_\_

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

FOR 1 - STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				94 06545 REG. NO.	
1. DECEASED'S NAME (First, Middle, Last) LYCILLE HILL				2. DATE OF DEATH MONTH 3 DAY 2 YEAR 94		3. TIME OF DEATH 2 PM	
4. SOCIAL SECURITY NUMBER 217 20 7339		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 68 YRS.	7. DATE OF BIRTH (Month, Day, Year) 5/4/25		8. BIRTHPLACE (State or Foreign Country) S.C.	
9a. FACILITY NAME (If not institution, give street and number) University of Maryland Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH City	
10a. STATE Md				10b. COUNTY Balto		10c. CITY, TOWN OR LOCATION Balto	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 3222 Dorithan Rd		10f. ZIP CODE 21215	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	
16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Admin. Supervisor				16b. KIND OF BUSINESS/INDUSTRY Federal Government		17. FATHER'S NAME (First, Middle, Last) Fletcher Cary	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Althea Thomas				19a. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3222 Dorithan Rd Balto, Md 21215		19b. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
20a. PLACE AND DATE OF DISPOSITION (Name of Cemetery, Crematory or other place) Woodlawn Cemetery 3/5/94				20b. LOCATION — City or Town, State Balto, Md		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gladys Warner	
22. NAME AND ADDRESS OF FACILITY Mack F. H. West 4300 Wabash Ave				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lack of cerebral blood flow b. Elevated intracranial pressure c. Cerebral Hemorrhage d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. DATE OF INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, Year) MAR 04 1994 32. REGISTRAR'S SIGNATURE			





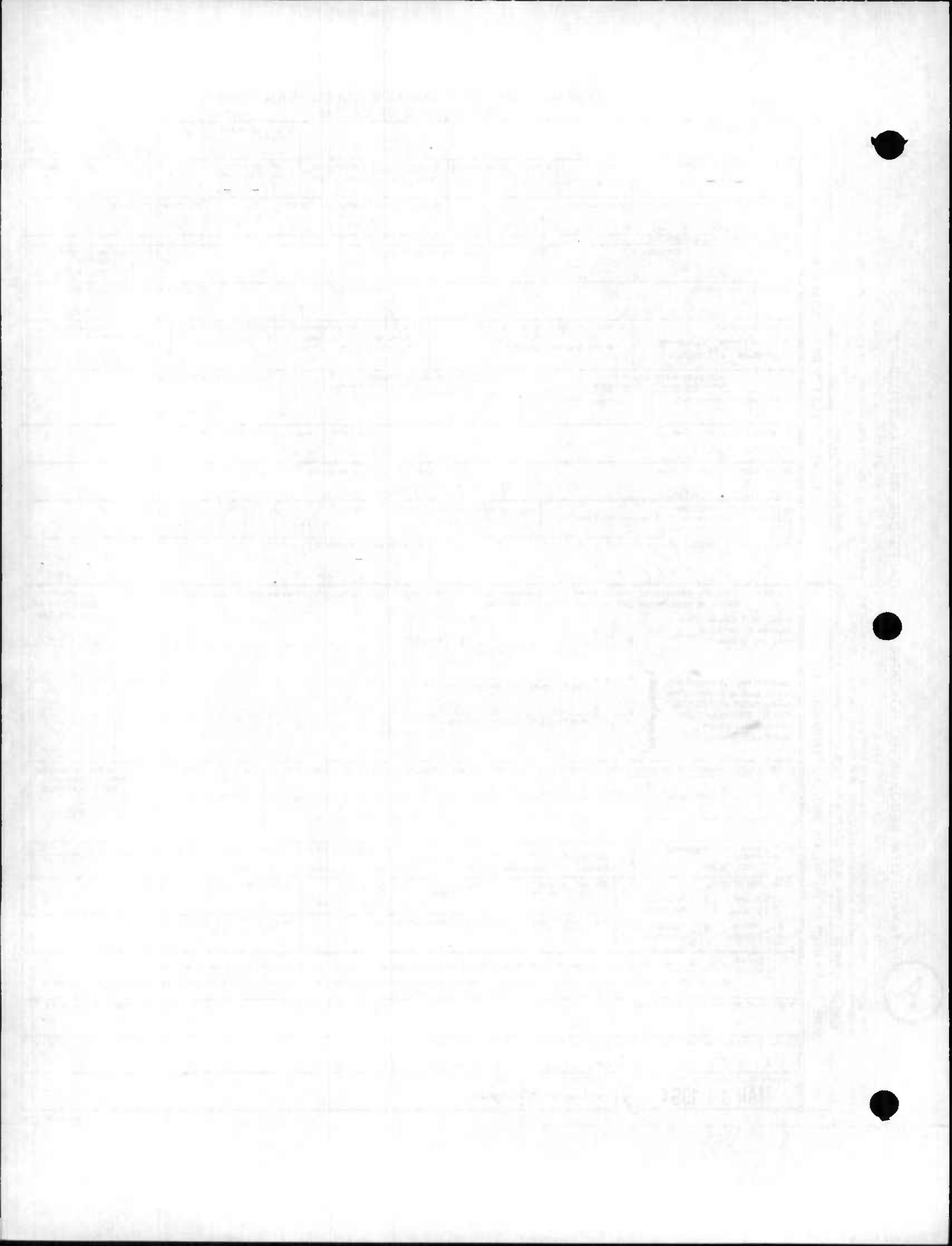
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06546

1. DECEDENT'S NAME (First, Middle, Last) <i>Mathilda Howell Mathilda A. Howell</i>				2. DATE OF DEATH MONTH <i>3</i> DAY <i>2</i> YEAR <i>94</i>		3. TIME OF DEATH <i>9:00 A M</i>							
4. SOCIAL SECURITY NUMBER <i>217-16-6164</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>75</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>10-11-1918</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>					
9a. FACILITY NAME (If not institution, give street and number) <i>Francis Scott Key Medical Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>				9c. COUNTY OF DEATH					
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Edgemere</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <i>7815 Denton Avenue</i>				10f. ZIP CODE <i>21219</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>6th Grade</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Secretary</i>		15b. KIND OF BUSINESS/INDUSTRY <i>Howell Trucking</i>									
17. FATHER'S NAME (First, Middle, Last) <i>William Parkent</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mamie Clark</i>									
19a. INFORMANT'S NAME (Type/Print) <i>Joan M. Groth</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7815 Denton Avenue Edgemere, Maryland 21219</i>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Oak Lawn Cemetery 3/5/1994</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Christina L. Lush</i>				22. NAME AND ADDRESS OF FACILITY <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</i>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Streptococcal septicemia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death <i>48 hrs</i>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>coronary artery disease; blood dyscrasia</i>								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Katelyn S. Reavis MD</i>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>3/2/94</i>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>110 Tower, Johns Hopkins Hospital Baltimore MD 21205</i>													
31. DATE FILED (Month, Day, Year) <i>MAR 04 1994</i>				32. REGISTRAR'S SIGNATURE <i>John S. Sanders-Randall</i>									


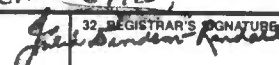


1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06547

1. DECEDENT'S NAME (First, Middle, Last) <b>Baseemah Hameen</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 2, 1994</b>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <b>349-50-0058</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>37</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Apr. 4, 1957</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Illinois</b>				9a. FACILITY NAME (If not institution, give street and number) <b>8213 Kilmorey Court</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Severn</b>	
9c. COUNTY OF DEATH <b>Anne Arundel</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Severn</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>8213 Kilmorey Court</b>	
10f. ZIP CODE <b>21144</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Homemaker</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Zeddie Crawford Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rebecca McIntosh</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jose L. DeJesus</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8213 Kilmorey Court, Severn, MD 21144</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Camp Butler Cemetery</b>		20c. LOCATION — City or Town, State <b>Springfield, IL</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RETROVIRAL INFECTION</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. <b>WASTING SYNDROME</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CYTOMEGALOVIRAL RETINITIS</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Raymond C. Y. Chung MD</b>				29c. LICENSE NUMBER <b>D30188</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RAYMOND C. Y. CHUNG MD, DEPT OF MEDICINE, WALTER REED HSP, WASHINGTON DC</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94-0945-510

B.K.S

94 06548

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARION HAWKINS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB. 25 94</b>		3. TIME OF DEATH <b>12:51 PM</b>	
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>64 YRS.</b>	7. DATE OF BIRTH (Month, Day, Year) <b>2-16-30</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>FRANCES SCOTT KEY MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1116 DUNDALK AVENUE</b>				10f. ZIP CODE <b>21224</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 YEARS</b> College (1-4 or 5+) <b>SOT II</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SOT II</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BALTO. CITY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>CLEMMON HAWKINS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GOLDIE HASKINS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. DELORES MITCHELL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GREEN MOUNT CEM 2-28</b>		20c. LOCATION — City or Town, State <b>BALTO. CITY MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Chuck Kaczorowski</i>				22. NAME AND ADDRESS OF FACILITY <b>KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVENUE BALTO. MD. 21222</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>Inquiry</b>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis A. Chute M.D.</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB. 25, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dennis Chute M.D. 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <i>John S. Sanders-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020



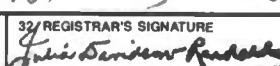
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06549

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Gladys Howell</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>1</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>212 62 68 53</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>05/10/1929</b>	
8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1310 Bowley's Quarters Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Middle River</b>	
9c. COUNTY OF DEATH <b>Baltimore County</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore County</b>	
10c. CITY, TOWN OR LOCATION <b>Middle River</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1310 Bowley's Quarters Road</b>	
10f. ZIP CODE <b>21220</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>9</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Farmer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Farm</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Luther Bryant</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dessie Haney</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Steward Howell (husband)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1310 Bowley's Quarters Road Middle River, Md 21220</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holly Hill Mem. Gardens 3/3/94</b>		20c. LOCATION — City or Town, State <b>Baltimore County, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Bruzdzinski Funeral Home P.A. 1407 Eastern Ave Baltimore, Maryland 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY Failure</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Cautionoma 4 pc paranas</b>  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>007890</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/1/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOSE F. HORTON MD 5601 LOCK KAYEN Bld Bldg rd 21239</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

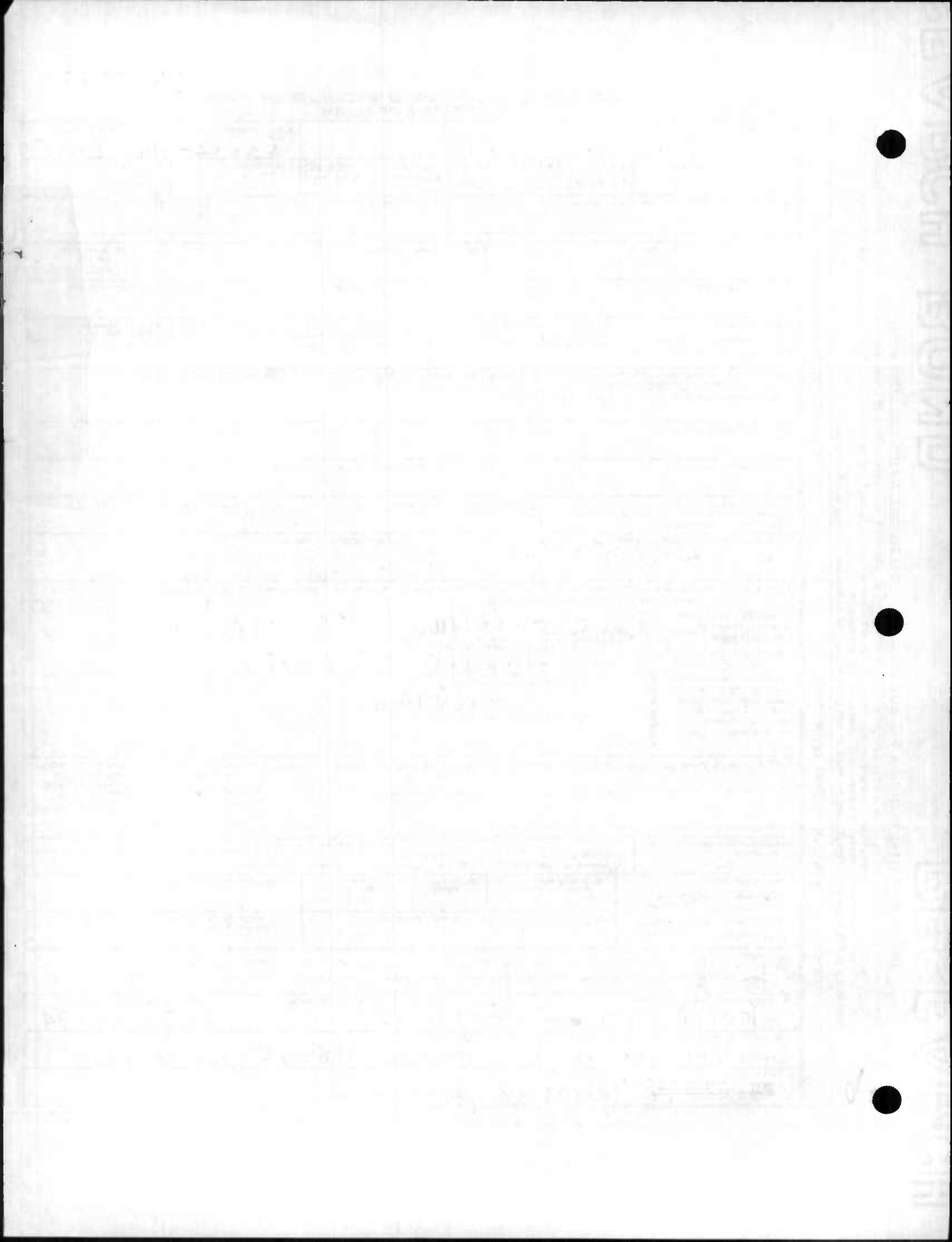
TO THE HOSPITAL OR AUTOPSY PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 25 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) <b>DORA V. HOYT</b>				2. DATE OF DEATH MONTH <b>03</b> - DAY <b>02</b> - YEAR <b>94</b>		3. TIME OF DEATH <b>8.20 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>220-64-4983</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 27, 1906</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Harbor Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MD</b>				10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Pasadena</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>7718 Notley Road</b>		10f. ZIP CODE <b>21122</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Household</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charles Duval</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine Brown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ralph W.R. Hoyt</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7670 Pine Knob Rd. Pasadena, MD. 21122</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glen Haven Cemetery 12/5/94</b>		20c. LOCATION — City or Town, State <b>Glen Burnie MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Hilary L. Stallings Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>-Stallings Funeral Home P.A. 3111 Mountain Rd. Pasadena, MD. 21122</b>			
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CONGESTIVE HEART FAILURE</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>ORTIC STENOSIS</b> <b>ANGINA</b>				Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND DATE OF CERTIFIER <b>Geoffrey Nana</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>03-02-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GEORGEY NANA, MD, HARBOR Hospital, Baltimore</b>				31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>			
32. REGISTRAR'S SIGNATURE <b>James R. Anderson</b>							



94 06551

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLARD CORNELIUS HARDESTY</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>28</b> YEAR <b>94</b>		3. TIME OF DEATH <b>10:45 AM</b>	
4. SOCIAL SECURITY NUMBER <b>705-10-2092</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <b>2</b> <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6-28-1910</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>		9c. COUNTY OF DEATH <b>A.A. COUNTY</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>PASADENA</b>	
10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>2785 MARSHY POINT LANE</b>				10f. ZIP CODE <b>21122</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 + 2</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>POST OFFICE SUPERVISOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>POST OFFICE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>CHARLES B. HARDESTY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CARRIE DAVIS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>WILLARD C. HARDESTY, SR.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>MARSHY POINT LANE, PASADENA, MD 21122</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. CARMEL CHURCH CEMETERY 13-4</b>		DATE <b>PASADENA, MD</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <b>STALLINGS FUNERAL HOME, P.A. 3111 MOUNTAIN ROAD, PASADENA, MD 21122</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Colon Cancer</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> Physician				29c. LICENSE NUMBER <b>041927</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/1/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JORGE PEREZ-ALARD, M.D./3708 MOUNTAIN ROAD/PASADENA, MARYLAND 21122</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

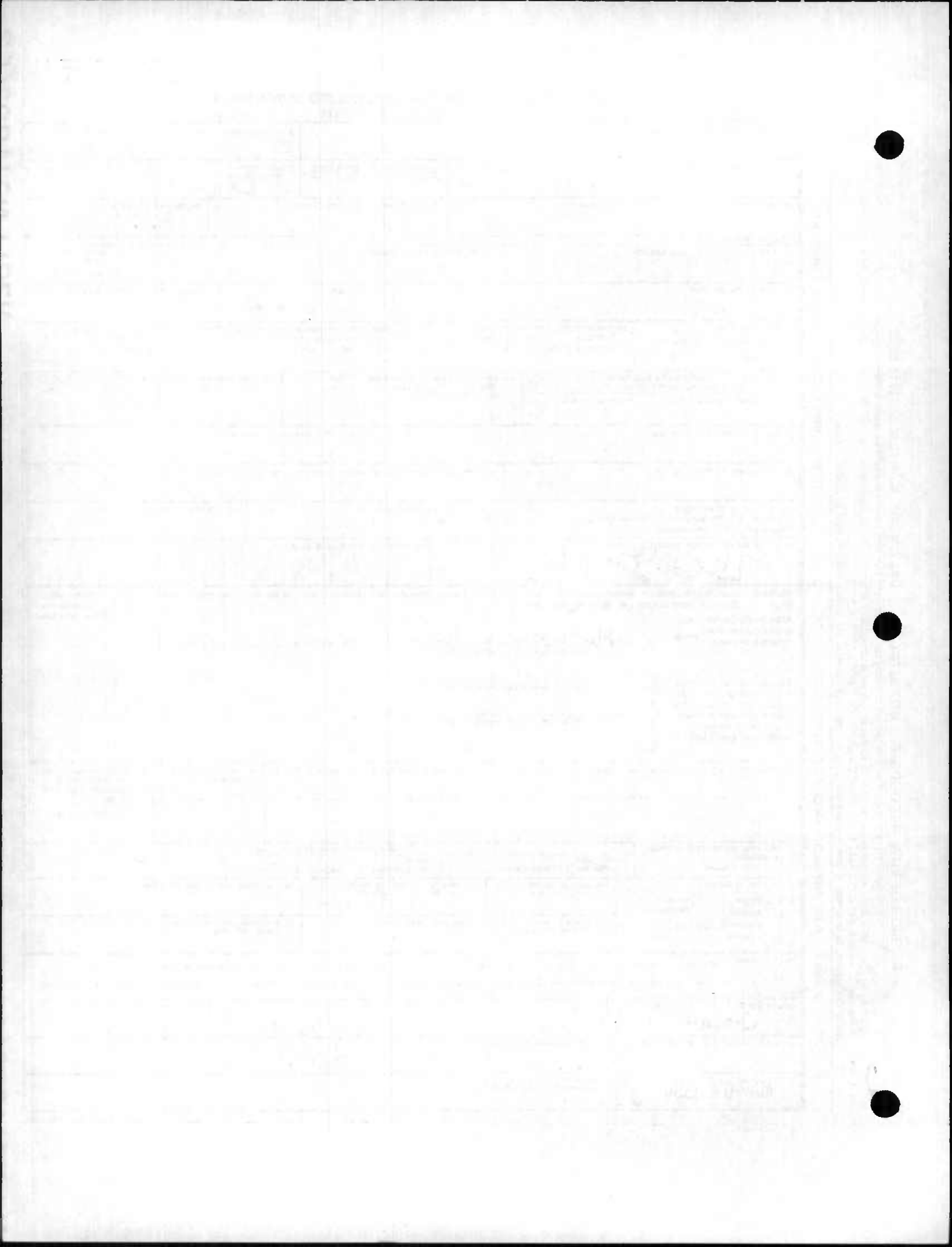
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06552

1. DECEDENT'S NAME (First, Middle, Last) CALVIN EARL HUTCHINSON				2. DATE OF DEATH MONTH DAY YEAR 2-9-94		3. TIME OF DEATH P M					
4. SOCIAL SECURITY NUMBER 217 18 5481		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 yrs YRS.		7. DATE OF BIRTH (Month, Day, Year) 11/11/24		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 400 North Curley St				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH na			
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY na		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 400 N. Curley Street				10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Yes WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver		16b. KIND OF BUSINESS/INDUSTRY Transportation					
17. FATHER'S NAME (First, Middle, Last) George Washington				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Elizabeth Hagan							
19a. INFORMANT'S NAME (Type/Print) Warren Hutchinson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 424 SE Marion, Des Moines, Iowa 50315							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE		20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. h/o Coronary of Colon DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostatic hypertrophy								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER R. Juente, MD.						29c. LICENSE NUMBER D21464		29d. DATE SIGNED (Month, Day, Year) 2-26-94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR ROBERT LIBERTO 3508 Bank Street, Baltimore, MD 21224											
31. DATE FILED (Month, Day, Year) MAR 04 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06553

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES F. HERRING</b>		2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>2ND</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>8 25 AM</b>	
4. SOCIAL SECURITY NUMBER <b>217-07-9820</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 4, 1920</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Good Samaritan Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore County</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>1709 Aberdeen Road, Apartment B</b>		10f. ZIP CODE <b>21234</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th Grade</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Custodian</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Baltimore County Board of Education</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charles P. Herring</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine Hopper</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Robert C. Herring</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4 Blue Spruce Drive, Hanover, Pennsylvania 17331</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith Cemetery 3/5</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kathleen M. Murphy</b>		22. NAME AND ADDRESS OF FACILITY <b>John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIOPULMONARY ARREST</b> DUE TO (OR AS A CONSEQUENCE OF): <b>CHRONIC RENAL FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>MULTIPLE MYELOMA</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death <b>1 DAY</b> <b>3 YEARS</b> <b>3 YEARS</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RIGHT LOBAR PNEUMONIA</b> <b>SEPSIS</b> <b>DEHYDRATION</b>					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>M.D.</b>			
29c. LICENSE NUMBER <b>P-07608</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 2 1994</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JAMES APPIAH-PIPPIN, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD BALTIMORE MD</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06554

1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN A JONES</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAR 3-1994</b>		3. TIME OF DEATH <b>2 AM</b>							
4. SOCIAL SECURITY NUMBER <b>213-48-5873</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>94</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>August 19, 1899</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Pickersgill Inc.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>				9c. COUNTY OF DEATH <b>Balto.</b>					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Balto.</b>		10c. CITY, TOWN OR LOCATION <b>Towson</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>615 Chestnut Ave.</b>				10f. ZIP CODE <b>21204</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>									
17. FATHER'S NAME (First, Middle, Last) <b>Herman Pieper</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eugenia Dorguth</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Pickersgill Inc.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>615 Chestnut Ave. 21204</b>									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery 3/4/94</b>		20c. LOCATION — City or Town, State <b>Balto. Md.</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald C. Shaker</i>				22. NAME AND ADDRESS OF FACILITY <b>1050 Tork Rd. 21204 Ruck Towson Funeral Home, Inc.</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>intracerebral hemorrhage</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Hypertension</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. <b>Hypertension</b> b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DJD</b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>M</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Anthony Riley M.D.</i>				29c. LICENSE NUMBER <b>D25205</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Anthony Riley M.D. G.B.M.C. Towson, Md. 21204</b>													
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>													



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06555

1. DECEDENT'S NAME (First, Middle, Last) <i>Evelyn Johnson</i>				2. DATE OF DEATH MONTH <i>3</i> DAY <i>1</i> YEAR <i>1994</i>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <i>214-30-2716</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>77</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>7-30-1916</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>1837 Portship Rd.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>Baltimore</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Md.</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1837 Portship Rd.</i>				10f. ZIP CODE <i>21222</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>William Icenroad</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Sarah Little</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Anna May Johnson</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1837 Portship Rd. Balto., Md. 21222</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Oak Lawn Cem.</i>		DATE <i>3/5</i>		20c. LOCATION — City or Town, State <i>Balto., Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Hantley Miller Funeral Home 7527 Hanford Rd. Balto., Md. 21234</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): <i>b. Chronic obstructive pulmonary disease (COPD)</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c.</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d.</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <i>one year</i> <i>5 years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Humbert G. [Signature] MD</i>				29c. LICENSE NUMBER <i>ESK# 94015</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/04/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Francis Scott Key Medical Center, Department of Medicine</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 04 1994</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

RECEIVED

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06556

1. DECEDENT'S NAME (First, Middle, Last) <u>Helen Jones</u> (Helen Anna Jones)				2. DATE OF DEATH MONTH <u>3</u> DAY <u>1</u> YEAR <u>94</u>		3. TIME OF DEATH <u>4:25A</u> M		
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <u>82</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <u>April 3, 1911</u>		
9a. FACILITY NAME (If not institution, give street and number) <u>Francis Scott Key</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore City</u>		9c. COUNTY OF DEATH <u>N/A</u>		
RESIDENCE OF DECEDENT								
10a. STATE <u>Maryland</u>		10b. COUNTY <u>N/A</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore City</u>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER <u>6916 Gough Street</u>				10f. ZIP CODE <u>21224</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8th Grade</u> College (1-4 or 5+) <u></u>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Tailor</u>		15b. KIND OF BUSINESS/INDUSTRY <u>Schoenman's</u>		
17. FATHER'S NAME (First, Middle, Last) <u>William York</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Anna Ahrens</u>				
19a. INFORMANT'S NAME (Type/Print) <u>Lillian J. Stack</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6919 Gough Street, Baltimore, Maryland 21224</u>				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of institution, cemetery or place of burial) <u>Benezet Methodist Church Cemetery</u>		DATE <u>3/4</u>		20c. LOCATION — City or Town, State <u>Baltimore, Maryland</u>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Kathleen M. Murphy</u>				22. NAME AND ADDRESS OF FACILITY <u>John C. Miller, Inc.</u> <u>6415 Belair Road, Baltimore, Maryland 21206</u>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Sepsis</u> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>hypothermia</u> <u>Dementia</u> <u>Hypertension</u>							Approximate Interval Between Onset and Death	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED				
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28e. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Francis Scott Key</u> MD				29c. LICENSE NUMBER <u>FSK 94129</u>		29d. DATE SIGNED (Month, Day, Year) <u>3/1/94</u>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Francis Scott Key Medical Center Baltimore MD</u>								
31. DATE FILED (Month, Day, Year) <u>MAR 04 1994</u>				32. REGISTRAR'S SIGNATURE <u>Juli Sanders</u>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the local health department within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE										94 06557					
1 - FOR STATE REGISTRAR										REG. NO.					
CERTIFICATE OF DEATH															
1. DECEDENT'S NAME (First, Middle, Last) Beatrice Cameron Judy				2. DATE OF DEATH 3-1-94 MONTH DAY YEAR March 1 1994				3. TIME OF DEATH 0814 M							
4. SOCIAL SECURITY NUMBER 225 12 2881		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-6-22		8. BIRTHPLACE (State or Foreign Country) Virginia							
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY				9c. COUNTY OF DEATH WICOMICO							
RESIDENCE OF DECEDENT															
10a. STATE Maryland		10b. COUNTY Wicomico County		10c. CITY, TOWN OR LOCATION Salisbury				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 1034 Riverside Drive				10f. ZIP CODE 21801				10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES no		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 12 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bookkeeper				16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) Beverly W. Cameron				18. MOTHER'S NAME (First, Middle, Maiden Surname) Weltie Morris											
19a. INFORMANT'S NAME (Type/Print) Kathy J. Thomas				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1034 Riverside Dr, Salisbury, MD 21801											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE				20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): b. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): c. Mitral Regurgitation DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death years					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> XDOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide a <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER Clayton J. Raab M.D.		29c. LICENSE NUMBER D19289		29d. DATE SIGNED (Month, Day, Year) 3/1/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Clayton J. Raab M.D. P.O. Box 2036 Salisbury MD 21801															
31. DATE FILED (Month, Day, Year) MAR 04 1994				32. REGISTRAR'S SIGNATURE John Davidson											

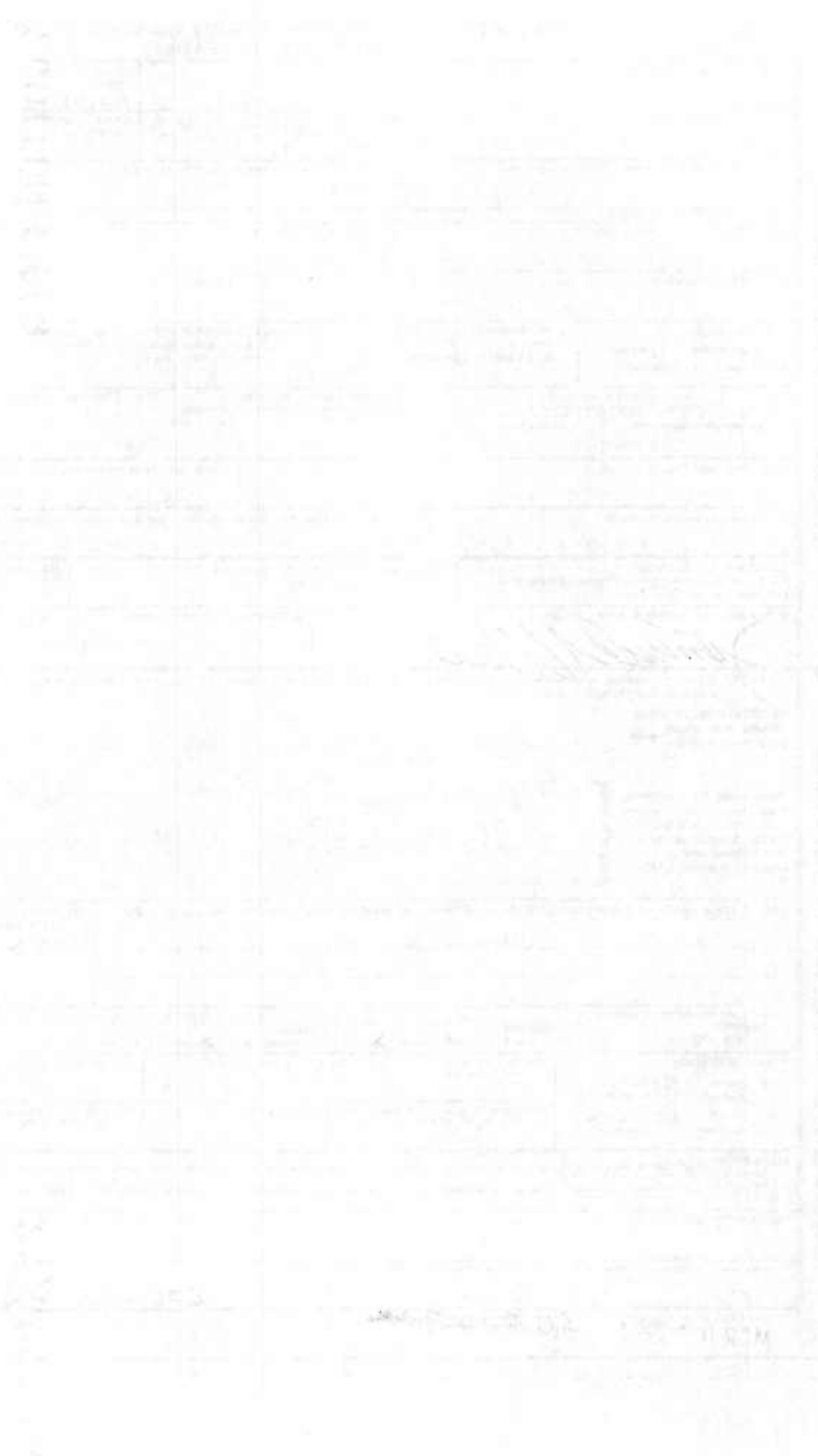
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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06558

1. DECEDENT'S NAME (First, Middle, Last) Albert Stanley Karczmarek				2. DATE OF DEATH MONTH 3 DAY 2 YEAR 94		3. TIME OF DEATH 10 <sup>45</sup> A M	
4. SOCIAL SECURITY NUMBER 217-26-8458 A		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 Years		7. DATE OF BIRTH 10/24/1926	
9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5135 King Avenue				10f. ZIP CODE 21237		10g. CITIZEN OF WHAT COUNTRY? U.S.A	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Meat Cutter Retired		16b. KIND OF BUSINESS/INDUSTRY Food			
17. FATHER'S NAME (First, Middle, Last) Stanley Karczmarek				18. MOTHER'S NAME (First, Middle, Maiden Surname) Victoria Baranoski			
19a. INFORMANT'S NAME (Type/Print) Margaret M. Karczmarek				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5135 King Ave. Baltimore, Maryland 21237			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Stanislaus Cemetery 3/7/94		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Martin J. Dippel Jr				22. NAME AND ADDRESS OF FACILITY The Dippel Funeral Home Inc 7110 Belair Road Baltimore, Maryland 21206			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Anoxic Encephalopathy DUE TO (OR AS A CONSEQUENCE OF): b. Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): c. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure Diabetes							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Steven J. Kravet MD				29c. LICENSE NUMBER MD04496A		29d. DATE SIGNED (Month, Day, Year) 3/2/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEVEN J. KRAVET, MD 4090 EASTERN AVE BALTIMORE, MD 21224							
31. DATE FILED (Month, Day, Year) MAR 04 1994				32. REGISTRAR'S SIGNATURE John S. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06559

1. DECEDENT'S NAME (First, Middle, Last) <b>Mary Anderson Krastel</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 2 94</b>		3. TIME OF DEATH HOURS MIN. SEC. <b>4:20 A.</b>					
4. SOCIAL SECURITY NUMBER <b>234-12-6995</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>93</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 11, 1900</b>					
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Manor Care Towson</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>					
9c. COUNTY OF DEATH <b>Balto.</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>					
10c. CITY, TOWN OR LOCATION <b>City</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>5614 Loch Raven Blvd.</b>					
10f. ZIP CODE <b>21239</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced					
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>Teacher</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Ohio School System</b>		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>Edmund Siebert</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Grace Anderson</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Thomas W. Leibforth</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7 Barnaby Ct. 21093</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Grdns 3/5/94 Timonium, Md.</b>		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>1050 York Rd. 21204 Ruck Towson Funeral Home, Inc.</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>s. Atherosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D29770</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-2-94</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A. Sergio Cassanego M.D. 8813 Waltham Woods Rd. 21234 Suite 201</b>			
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE 							

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06560

1. DECEDENT'S NAME (First, Middle, Last) <b>Koehler Louis James Koehler</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>97</b> YEAR		3. TIME OF DEATH <b>6:37</b> <b>PM</b>	
4. SOCIAL SECURITY NUMBER <b>219-10-8659</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-30-1925</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Baltimore V. A. Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Edgemere</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>7607 Chesapeake Drive</b>				10f. ZIP CODE <b>21219</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (8-12)</b> <b>12th Grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mechanic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Automobile</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Fred Koehler</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Julia Martha Fisteck</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Donna M. Daniels</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7607 Chesapeake Drive Edgemere, Maryland 21219</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery 3/5/1994</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Christina L. Lyle</i>				22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Head + Neck CA</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>heart failure</b> <b>respiratory failure</b> <b>renal failure</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>3/3/94</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Eric Greenberg MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Eric Greenberg</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ALUMINUM BOILER

SECTION 1

SECTION 2

SECTION 3



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Margaret G. KORPON</i>				2. DATE OF DEATH MONTH <i>03</i> DAY <i>03</i> YEAR <i>94</i>		3. TIME OF DEATH <i>4 A</i> M	
4. SOCIAL SECURITY NUMBER <i>144 18 4826</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>68</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Nov. 3, 1925</i>	
8. BIRTHPLACE (State or Foreign Country) <i>New Jersey</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Anne Arundel Medical Center</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Annapolis</i>	
9c. COUNTY OF DEATH <i>Anne Arundel</i>				10a. STATE <i>MD</i>		10b. COUNTY <i>Anne Arundel</i>	
10c. CITY, TOWN OR LOCATION <i>Odenton</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>606 Rollinghill Walk #101</i>	
10f. ZIP CODE <i>21113</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Secretary</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Banking</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Bernhard P. Guttormsen</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Margit Gulbrandsen</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Steven B. Korpon</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>900 Barbury Place, Annapolis, MD 21401</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Maryland Veterans Cemetery</i>			
20c. LOCATION — City or Town, State <i>Crownsville, MD</i>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>			
22. NAME AND ADDRESS OF FACILITY <i>Hardesty Funeral Home, P.A. 12 Ridgely Ave., Annapolis, MD 21401</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Congestive Heart Failure</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <i>M</i>			
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Emily W. Collier MD</i>			
29c. LICENSE NUMBER <i>D16354</i>				29d. DATE SIGNED (Month, Day, Year) <i>3/3/94</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Enser W. Collier 900 Bestgate Rd Suite 300 Annapolis MD 21401</i>				31. DATE FILED (Month, Day, Year) <i>MAR 04 1994</i>			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HUMANITARIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06562

1. DECEDENT'S NAME (First, Middle, Last) <b>ANNA LEIMBACH</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>28</b> YEAR <b>94</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>220-18-5082</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>93</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-27-1900</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. COUNTY OF DEATH <b>Baltimore</b>			
10. FACILITY NAME (If not institution, give street and number) <b>Charlestown Care Center</b>				11. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>			
12. RESIDENCE OF DECEDENT				13. COUNTY OF DEATH <b>Baltimore</b>			
14a. STATE <b>Md</b>		14b. COUNTY <b>Baltimore</b>		14c. CITY, TOWN OR LOCATION <b>Baltimore</b>		14d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
15a. STREET AND NUMBER <b>715 Maiden Choice Lane</b>				15b. ZIP CODE <b>21228</b>		15c. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
16. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		17. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		19. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Cashier- Bookkeeper</b>		22. KIND OF BUSINESS/INDUSTRY <b>Stationery Store</b>			
23. FATHER'S NAME (First, Middle, Last) <b>Peter J. Leimbach</b>				24. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Caroline Enbes</b>			
25. INFORMANT'S NAME (Type/Print) <b>Mrs. Eleanor L. Hildebrand</b>				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>715 Maiden Choice Lane Balto., Md. 21228</b>			
27a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		27b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parkwood Cem.</b>		27c. DATE <b>3/3</b>		27d. LOCATION — City or Town, State <b>Balto., Md</b>	
28. SIGNATURE OF FUNERAL SERVICE LICENSEE 				29. NAME AND ADDRESS OF FACILITY <b>Hantley Miller Funeral Home 7527 Hanford Rd. Balto., Md. 21234</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Malnutrition / Dehydration</b>							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D42678</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/28/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Alan McBride 711 Maiden Choice Ln Catonsville MD 21228</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06563

1. DECEDENT'S NAME (First, Middle, Last) <i>Daniel Thomas Mulheran</i>				2. DATE OF DEATH MONTH <i>2</i> DAY <i>25</i> YEAR <i>1994</i>		3. TIME OF DEATH <i>10:35 P M</i>	
4. SOCIAL SECURITY NUMBER <i>232-20-6084</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>73</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>1-4-1921</i>	
8. FACILITY NAME (If not institution, give street and number) <i>3006 Dunglew Road</i>				9. CITY, TOWN OR LOCATION OF DEATH <i>Dundalk</i>		10. COUNTY OF DEATH <i>Baltimore</i>	
11. RESIDENCE OF DECEDENT 10a. STATE <i>Maryland</i> 10b. COUNTY <i>Baltimore</i> 10c. CITY, TOWN OR LOCATION <i>Dundalk</i>				12. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
13. STREET AND NUMBER <i>3006 Dunglew Road</i>				14. ZIP CODE <i>21222</i>		15. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
16. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		17. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>U.S. Army WW II</i>		18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		19. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th Grade</i> College (1-4 or 5+) <i>1 Year Coll.</i>				21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Executive Vice President</i>		22. KIND OF BUSINESS/INDUSTRY <i>Ruck Funeral Homes</i>	
23. FATHER'S NAME (First, Middle, Last) <i>Daniel Phillip Mulheran</i>				24. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Theresa Delia Cross</i>			
25. INFORMANT'S NAME (Type/Print) <i>Frances L. Mulheran</i>				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3006 Dunglew Road Dundalk, Maryland 21222</i>			
27. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Stanislaus Cem. 3/2/1994</i>		29. LOCATION — City or Town, State <i>Dundalk, Maryland</i>		30. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael J. Ruck</i>	
31. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>PANCREATIC CANCER</i> DUE TO (OR AS A CONSEQUENCE OF): a. <i>PANCREATIC CANCER</i> b. c. d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		32. NAME AND ADDRESS OF FACILITY <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</i>		33. APPROXIMATE Interval Between Onset and Death <i>7 MONTHS</i>		34. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>LIVER METASTASES PERITONEAL METASTASES</i>	
35. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		36. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		37. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		38. 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
39. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		40. 28a. DATE OF INJURY (Month, Day, Year)		41. 28b. TIME OF INJURY <i>M</i>		42. 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
43. 28d. DESCRIBE NOW INJURY OCCURRED		44. 26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		45. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		46. 29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>Eric Seifter</i> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
47. 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Eric Seifter</i>				48. 29c. LICENSE NUMBER <i>D29373</i>		49. 29d. DATE SIGNED (Month, Day, Year) <i>2/28/94</i>	
50. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr. Eric Seifter 611 Park Avenue</i>							
51. DATE FILED (Month, Day, Year) <i>MAR 04 1994</i>		52. REGISTRAR'S SIGNATURE <i>Julia Sanderson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

PHOTO BOARD

NO. 10101 5165

RESERVE

APR 2 1961

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06564

1. DECEDENT'S NAME (First, Middle, Last) <i>Viola Moreland</i>				2. DATE OF DEATH MONTH <i>3</i> DAY <i>1</i> YEAR <i>94</i>		3. TIME OF DEATH <i>4 45 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>212-30-3183</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>60</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>12/6/1933</i>	
9a. FACILITY NAME (If not Institution, give street and number) <i>Francis Scott Key Medical Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>Baltimore City</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1401 Kuper Street</i>				10f. ZIP CODE <i>21223</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>3 Years</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Nurse</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Nursing Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>John Kasper</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Petroin Kapacinska</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Ella P. Chance</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6216 Elliott Street Baltimore, Maryland 21224</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Hilltop Service Corp. 3/4/94</i>		20c. LOCATION — City or Town, State <i>Towson, Maryland</i>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Johnny L. Kasper</i>				22. NAME AND ADDRESS OF FACILITY <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Hepatic failure</i> DUE TO (OR AS A CONSEQUENCE OF): <i>b. liver cirrhosis</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c.</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d.</i>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal failure</i> <i>Encephalopathy</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Kasper</i>				29c. LICENSE NUMBER <i>FSK 94129</i>		29d. DATE SIGNED (Month, Day, Year) <i>3-1-94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Francis Scott Key Med Center, Baltimore MD</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 04 1994</i>				32. REGISTRAR'S SIGNATURE <i>John Kasper</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06565

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FRANCIS JOSEPH MORGAN</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>1</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>215-01-5844</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10/29/17</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Multi-Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Carney</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2419 Harwood Road</b>				10f. ZIP CODE <b>21234</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 yrs</b> College (1-4 or 5+) <b>Truck Driver</b>				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Crown Petroleum Corp.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Thomas Morgan</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Gately</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John J. Morgan</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8604 Quentin Ave. Baltimore, MD 21234</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Moreland Memorial Park 3/5/94</b>		20c. LOCATION — City or Town, State <b>Hillendale, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21286</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebrovascular disease with CVA</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Generalized atherosclerosis</b>						Approximate Interval Between Onset and Death <b>2 wks</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>atrial fibrillation Polyarticular gout</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE NOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Dr. Habersat</b>				29c. LICENSE NUMBER <b>D18822</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Habersat 120 Sister Pierre Dr. Suite 207</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STANDARD FORM

NO. 100-100000-100000

STANDARD FORM

NO. 100-100000-100000

APR 10 1954



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06566

1. DECEDENT'S NAME (First, Middle, Last) <b>Edwin E. MELNIKOFF</b>				2. DATE OF DEATH MONTH <b>Feb</b> DAY <b>28</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>3:30 P</b> M	
4. SOCIAL SECURITY NUMBER <b>214-24-5608</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>APR. 5, 1928</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>LEVINDALE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5516 CADILLAC AVENUE</b>				10f. ZIP CODE <b>21207</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>PLUMBER</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PLUMBER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>PLUMBING</b>			
17. FATHER'S NAME (First, Middle, Last) <b>HARRY MELNIKOFF</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA SHAPIRO</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MR. LIONEL SHAPIRO</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>915 BURNT CREST LANE SILVER SPRING, MD 20903</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BNAI ISRAEL</b>		DATE <b>3-2-94</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sydney L. Stillman</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD BALTIMORE, MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Metastatic PAROTID CANCER - Mucoepidermoid</b>							
b. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Debra S Wertheimer MD</i>				29c. LICENSE NUMBER <b>D23767</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/28/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DEBRA S WERTHEIMER MD 2434 W. BELVEDERE AVE BALTO MD 21215</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julius B. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06567

1. DECEDENT'S NAME (First, Middle, Last) <i>Clarence Meyer</i>				2. DATE OF DEATH MONTH DAY YEAR <i>February 27 1994</i>				3. TIME OF DEATH <i>11 25 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>114-03-4009</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>85</i> YRS.		7. DATE OF BIRTH MONTH DAY YEAR <i>5/1/1908</i>		8. BIRTHPLACE (State or Foreign Country) <i>NEW YORK</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>SINAI HOSPITAL</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i>				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>BALTIMORE</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>3202 OLD POST DR APT 5</i>				10f. ZIP CODE <i>21208</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WWII ARMY</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>College (1-4 or 5+)</i> <i>2</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>SALESMAN</i>		16b. KIND OF BUSINESS/INDUSTRY <i>PAPER BOXES</i>			
17. FATHER'S NAME (First, Middle, Last) <i>MAX MEYER</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>MINNIE</i>					
19a. INFORMANT'S NAME (Type/Print) <i>MRS NATALIE MEYER</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3202 OLD POST DR APT 5 BALTO MD 21208</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>HAR SINAI 3/1/94</i>		DATE <i>3/1/94</i>		20c. LOCATION — City or Town, State <i>OWINGS MILLS MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Glennine Lumsden</i>				22. NAME AND ADDRESS OF FACILITY <i>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Acute Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <i>b. Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide  28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY <i>M</i>  28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  28d. DESCRIBE HOW INJURY OCCURRED  28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sam Sencil Medical Intern</i>  29c. LICENSE NUMBER  29d. DATE SIGNED (Month, Day, Year) <i>February 27, 1994</i>  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Sam Sencil Sinai Hospital, Baltimore, MD.</i>  31. DATE FILED (Month, Day, Year) <i>MAR 04 1994</i>  32. REGISTRAR'S SIGNATURE <i>John Sanders-Randall</i>									

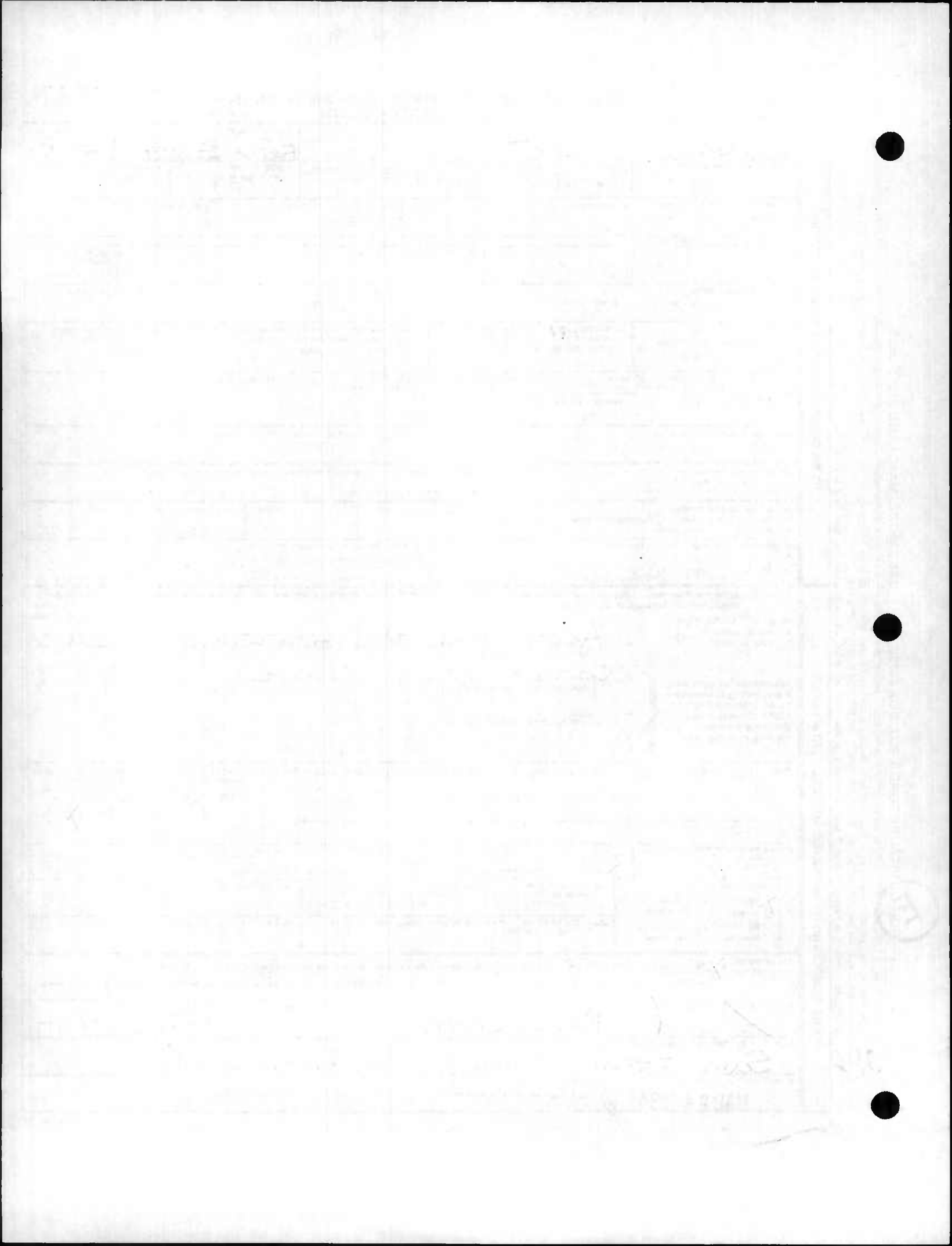
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE MEDICAL EXAMINER: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06568

1. DECEDENT'S NAME (First, Middle, Last) <b>CLIFFORD EUGENE MARSHALL SR.</b>				2. DATE OF DEATH MONTH <b>FEB.</b> DAY <b>28</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>12:15 P M</b>	
4. SOCIAL SECURITY NUMBER <b>579-16-3063</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN. 30, 1921</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>800 MOTTER AVENUE #710</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>FREDERICK</b>		9c. COUNTY OF DEATH <b>FREDERICK</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>FREDERICK</b>		10c. CITY, TOWN OR LOCATION <b>FREDERICK</b>		10d. INSIDE CITY LIMITS? <b>1 X YES 2 NO</b>	
10e. STREET AND NUMBER <b>800 MOTTER AVENUE #710</b>				10f. ZIP CODE <b>21701</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS <b>1 Never Married 2 Married</b> <b>3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 X YES 2 NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 X NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TRUCK DRIVER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CONSTRUCTION</b>			
17. FATHER'S NAME (First, Middle, Last) <b>SAMPSON MARSHALL</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CLARA SMITH</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CLIFFORD E. MARSHALL JR.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1924 GILLIS FALLS ROAD WOODBINE, MD. 21797</b>			
20a. METHOD OF DISPOSITION <b>1 X Burial 2 Cremation 3 Removal from State</b> <b>4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <b>MT. CARMEL CEMETERY</b>		DATE <b>3/4</b>		20c. LOCATION — City or Town, State <b>SUNSHINE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Muriel H. Barber</i>				22. NAME AND ADDRESS OF FACILITY <b>MURIEL H. BARBER FUNERAL HOME 20882 21525 LAYTONSVILLE RD. LAYTONSVILLE, MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardiac arrest</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. Emphysema</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Sleep apnea</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 X NO</b>
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 X NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>					
27. MANNER OF DEATH <b>1 Natural 5 Pending Investigation</b> <b>2 Accident 8 Could not be determined</b> <b>3 Suicide 4 Homicide</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <b>1 X CERTIFYING PHYSICIAN:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2 MEDICAL EXAMINER:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>H. H. H. H.</i>				29c. LICENSE NUMBER <b>PMU-1</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/28/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>H. H. H. H. 1475 Hwy 401, Frederick MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Russell</i>			



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06569

1. DECEDENT'S NAME (First, Middle, Last) <i>William R. Minnix</i>				2. DATE OF DEATH MONTH DAY YEAR <i>2 28 94</i>		3. TIME OF DEATH <i>4:40 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>579-34-9802</i>		5. SEX <i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>83</i> YRS.		7. DATE OF BIRTH MONTH DAY YEAR <i>Jan 15 1911</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Francis Scott Key Hosp.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <i>MD</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>Baltimore City</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>829 S. Bond Street</i>				10f. ZIP CODE <i>21231</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Contracting</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Self-employed</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Alex Minnix</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Willie Eve Smithson</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Berwood E. Minnix</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>829 S. Bond Street, Baltimore, MD 21231</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Metro Crematory, Inc. Mar 4</i>		20c. LOCATION — City or Town, State <i>Catonsville</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dean P Charlton</i>				22. NAME AND ADDRESS OF FACILITY <i>Charlton Funeral Home 2007 Eastern Ave., Baltimore, MD 21231</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Aspiration pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. DUE TO (OR AS A CONSEQUENCE OF):</i> <i>c. DUE TO (OR AS A CONSEQUENCE OF):</i> <i>d. DUE TO (OR AS A CONSEQUENCE OF):</i>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Airway Disease</i>							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Goldstein</i>				29c. LICENSE NUMBER <i>94003</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/28/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr. Goldstein FSK Medical Center</i>							
31. DATE FILED (Month, Day, Year) <i>2/ MAR 04 1994</i>				32. REGISTRAR'S SIGNATURE <i>John Benison-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL: ONCE THE PHYSICIAN has signed this certificate, the law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06570

1. DECEDENT'S NAME (First, Middle, Last) ROSE NOVAK				2. DATE OF DEATH MONTH DAY YEAR 5 3 94		3. TIME OF DEATH 800 A M			
4. SOCIAL SECURITY NUMBER 219-10-3382		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 97 Years		7. DATE OF BIRTH (Month, Day, Year) 07/19/1896		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Brightwood Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH Baltimore	
10a. STATE MD		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Towson				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 518 Hampton Lane				10f. ZIP CODE 21286		10g. CITIZEN OF WHAT COUNTRY U.S.A			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home					
17. FATHER'S NAME (First, Middle, Last) William Jackowiak				18. MOTHER'S NAME (First, Middle, Maiden Surname) Veronica Priezski					
19a. INFORMANT'S NAME (Type/Print) Elizabeth Shinosky				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 518 Hampton Lane Towson Md. 21211					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross Polish Nat. Cem. 3/5/94		20c. LOCATION — City or Town, State Baltimore					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John J. Dippel				22. NAME AND ADDRESS OF FACILITY The Dippel Funeral Home INC 7110 Belair Road Baltimore, Maryland 21206					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Dementia - Alzheimer Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. AJHD						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Simon Bardin MD		29c. LICENSE NUMBER D25695		29d. DATE SIGNED (Month, Day, Year) 3-3-94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Simon Bardin 711 W. 40th St Baltimore MD 21211									
31. DATE FILED (Month, Day, Year) MAR 04 1994				32. REGISTRAR'S SIGNATURE John B. Borden					

1110 Belair Road Baltimore, Maryland 21206  
The Dippel Funeral Home Inc.  
Baltimore

FOR  
STATE  
1 - REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06571

1. DECEDENT'S NAME (First, Middle, Last) <b>JOSEPH ORENSTEIN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 28, 1994</b>		3. TIME OF DEATH <b>3:07 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>215-32-4215</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 1, 1902</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>		9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2816 SMITH AVENUE</b>				10f. ZIP CODE <b>21209</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PROPRIETOR</b>		15b. KIND OF BUSINESS/INDUSTRY <b>AUTO REPAIRS</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ABRAHAM ORENSTEIN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FANNIE SILVER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. ARLENE FALKE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3309 Fallstaff Rd., Baltimore, Md 21215</b> <b>915 BURNETT CREST LANE SILVER SPRING, MD 20903</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>RODFE ZEDEK - 3-2-94</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>		20d. DATE <b>3-2-94</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ellensue Levinson</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD BALTIMORE, MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial infarction 20 to Coronary VASCULAR DISEASE</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND DATE OF CERTIFIER <i>James G. Stuart MD</i> <b>10-1</b>		29c. LICENSE NUMBER <b>9789</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/28/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JAMES G. STUART MD 10-1 SINAI HOSPITAL HUSBERT</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>		32. REGISTRAR'S SIGNATURE <i>John Sanders-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the

document is a list of

the names of the

persons who have been

in the past, and who are

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06572

1. DECEDENT'S NAME (First, Middle, Last) <b>VERBLE ODOM</b>				2. DATE OF DEATH MONTH <b>FEBRUARY</b> DAY <b>27</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>2:50 A M</b>	
4. SOCIAL SECURITY NUMBER <b>240-24-8891</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-8-20</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>SINAI</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>BALTO</b>		8c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTO</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4038 W. COLDSRING LANE 1ST FL.</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8TH</b> College (1-4 or 5+) <b>CONSTRUCTION WORKER</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>WADE ODOM</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>OLIVE MAE QUICK</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FLORENCE G. ODOM</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4038 W. COLDSRING LANE BALTO, MD 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place) <b>WESTERN STAR</b>		DATE <b>3594</b>		20c. LOCATION — City or Town, State <b>CATONSVILLE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sala March</i>				22. NAME AND ADDRESS OF FACILITY <b>WESTERN STAR</b> March Funeral Home— West 4300 Wabash Ave.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SMALL CELL CARCINOMA OF LUNG</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
29b. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29c. DATE SIGNED (Month, Day, Year) <b>FEB 27, 1994</b>			
29d. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29e. SIGNATURE AND TITLE OF CERTIFIER <i>James G. Smart DO</i>			
29f. LICENSE NUMBER <b>X9789</b>				29g. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JAMES G. SMART DO PGY-1, SINAI HOSPITAL INTERNAL MED HUSB</b>			
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <i>John Sanders</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-15-1972

10-15-1972

10-15-1972

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10-15-1972

P

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

94 06573

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lee Roy Outlaw</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 3, 1994</b>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <b>237-03-0998</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 14, 1914</b>	
8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>				9a. FACILITY NAME (If not institution, give street and number) <b>8239 Reece Heights Drive</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Severn</b>	
9c. COUNTY OF DEATH <b>Anne Arundel</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Severn</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>8239 Reece Heights Drive</b>	
10f. ZIP CODE <b>21144</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Army Officer</b>				16b. KIND OF BUSINESS/INDUSTRY <b>US Army</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William H. Outlaw</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ola Veale</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Louise B. Outlaw</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8239 Reece Heights Drive, Severn, MD 21144</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arlington National Cem.</b>			
20c. LOCATION — City or Town, State <b>ARlington VA</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Bob J. [Signature]</i>			
22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401</b>				23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. metastatic colon carcinoma</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Raymond B. Weiss</i>			
29c. LICENSE NUMBER <b>D34004</b>				29d. DATE SIGNED (Month, Day, Year) <b>MARCH 3, 1994</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Whitner Reed Hosp Washington, DC</b>				31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>			
32. REGISTRAR'S SIGNATURE <i>John Andrew [Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate must be signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				94 06574	
CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <b>ANNA I. PAUL</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>27</b> YEAR <b>94</b>		3. TIME OF DEATH <b>5:30 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>219-30-6392</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>84</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>06-08-09</b>	8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>		
9a. FACILITY NAME (If not Institution, give street and number) <b>UNIVERSITY HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7843 AMERICANA CIRCLE</b>				10f. ZIP CODE <b>21061</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>THOMAS SHANAHAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>IRENE MCGEE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARIA LOIS MINGIONI (DAUGHTER)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>102 CROMWELL AVENUE FERNDALE MARYLAND 21061</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LOUDON PARK CEMETERY</b>		DATE <b>03/03/94</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>LEROY M &amp; RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>respiratory failure</b> DUE TO (OR AS A CONSEQUENCE OF):  b. <b>systemic candidiasis</b> DUE TO (OR AS A CONSEQUENCE OF):  c. <b>recurrent AML</b> DUE TO (OR AS A CONSEQUENCE OF):  d.  Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>			
29c. LICENSE NUMBER <b>D36131</b>				29d. DATE SIGNED (Month, Day, Year) <b>3/1/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>University of MD Cancer Center</b>							
31. DATE FILED (Month, Day, Year) <b>3/MAR 4 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06575

1. DECEDENT'S NAME (First, Middle, Last) <b>Kathleen Rose Porter</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>02</b> YEAR <b>94</b>		3. TIME OF DEATH <b>10:30 am</b>									
4. SOCIAL SECURITY NUMBER <b>213-05-3673</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Mar. 17, 1918</b>		8. BIRTHPLACE (State or Foreign Country) <b>Kentucky</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>3413 Keene Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>			9c. COUNTY OF DEATH								
RESIDENCE OF DECEDENT				10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>							
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>3413 Keene Avenue</b>		10f. ZIP CODE <b>21214</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Housewife</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY									
17. FATHER'S NAME (First, Middle, Last) <b>Alfonse Rassa</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Cunnigunda Doerfler</b>											
19a. INFORMANT'S NAME (Type/Print) <b>Kathleen F. McCloskey</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6113 Fair Oak Ave. Baltimore, Md. 21214</b>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith 3/5/94</b>		DATE		20c. LOCATION — City or Town, State <b>Baltimore Maryland</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Milton J. Knight Jr</b>				22. NAME AND ADDRESS OF FACILITY <b>Baltimore, Md. 21214 Leonard J. Ruck, Inc. 5305 Harford Road</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ischemic Heart Disease</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death <b>years</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>		29c. LICENSE NUMBER <b>20835V</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/2/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GRACIE Y. PATRICK</b>															
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06576

1. DECEDENT'S NAME (First, Middle, Last) DONALD RANDOLPH PRICE				2. DATE OF DEATH MONTH DAY YEAR March 3, 1994		3. TIME OF DEATH 1:30 A. M.					
4. SOCIAL SECURITY NUMBER 232-05-4081		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-27-1917		8. BIRTHPLACE (State or Foreign Country) Indiana			
9a. FACILITY NAME (If not institution, give street and number) 6910 Old Harford Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City				9c. COUNTY OF DEATH			
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore City				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 6910 Old Harford Rd.				10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yr's		College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chauffeur		16b. KIND OF BUSINESS/INDUSTRY Genstar					
17. FATHER'S NAME (First, Middle, Last) Harry R. Price				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Pool							
19a. INFORMANT'S NAME (Type/Print) Mrs. Gertrude M. Price				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge 3/5/94		DATE		20c. LOCATION — City or Town, State Dorsey, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Paul L. Hartsock, Jr.				22. NAME AND ADDRESS OF FACILITY Baltimore, MD 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Respiratory failure</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Emphysema</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 5 yrs			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Howard S. Freeland						29c. LICENSE NUMBER D28127		29d. DATE SIGNED (Month, Day, Year) 3/3/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Howard S. Freeland, M.D. 5601 Loch Raven Blvd. Russell Morgan Building 3rd Floor											
31. DATE FILED (Month, Day, Year) MAR 04 1994				32. REGISTRAR'S SIGNATURE John Andrew Ruckelshaus							



94 06577

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BERNARD				2. DATE OF DEATH MONTH DAY YEAR FEB. 27, 1994				3. TIME OF DEATH 1:40 PM M	
4. SOCIAL SECURITY NUMBER 216-05-1144		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEB. 18, 1911		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) MILFORD MANOR NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 6962 MILBROOK PARK DRIVE, APT. 1D				10f. ZIP CODE 21215	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) SALESMAN	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALESMAN				16b. KIND OF BUSINESS/INDUSTRY LIQUOR				17. FATHER'S NAME (First, Middle, Last) ISAAC PLIMACK	
18. MOTHER'S NAME (First, Middle, Maiden Surname) JENNIE SILVERMAN				19a. INFORMANT'S NAME (Type/Print) MRS EDITH PLIMACK				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6962 MILBROOK PARK DRIVE, APT. 1D BALTIMORE, MD 21215	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SHAAREI TFILOH 3-1-94 BALTIMORE, MD				20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CEREBRAL THROMBOSIS DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
24. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Tasneem Salihani MD				29c. LICENSE NUMBER D28585	
29d. DATE SIGNED (Month, Day, Year) 2/28/94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TASNEEM LAHMANI, 7220 PARK HEIGHTS AVE BALD MD 21208				31. DATE FILED (Month, Day, Year) MAR 04 1994	
32. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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OF THE  
CONGRESS

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JAN 10 1900

MAY 10 1900



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06578

1. DECEDENT'S NAME (First, Middle, Last) <b>Margaret Ramsey Pikey</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>3</b> YEAR <b>94</b>		3. TIME OF DEATH <b>3/ A</b> M					
4. SOCIAL SECURITY NUMBER <b>213-28-8104</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>04/06/03</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Charlestown Care Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Catonsville</b>				9c. COUNTY OF DEATH <b>Baltimore</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Catonsville</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>711 Maiden Choice Lane, Apt. 1305</b>				10f. ZIP CODE <b>21228</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Business Owner</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Nursery/Day Care Center</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Thomas Skelton</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine Doyle</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Michael P. Harrison</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>31 Eastford Court Baltimore, MD 21234</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. John's Cemetery 3/5</b>		DATE <b>3/3/94</b>		20c. LOCATION — City or Town, State <b>Long Green, MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>George E. MacNabb</b>				22. NAME AND ADDRESS OF FACILITY <b>MacNabb Funeral Home, P.A. 301 Frederick Road Balto., MD 21228</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Cardiovascular failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Cardiomyopathy</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Aortic stenosis</b> DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death <b>1 year</b> <b>1 year</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>possible pneumonia</b> <b>chronic renal insufficiency</b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Paul J. Hufsch</b>				29c. LICENSE NUMBER <b>D26473</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/94</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BF Kalowsky, MD 711 MAIDEN CHOICE LA, BALTO., MD</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <b>John B. ...</b>							



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06579

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles Harry Payne</b>				2. DATE OF DEATH MONTH <b>FEB</b> DAY <b>25</b> YEAR <b>1994</b>				3. TIME OF DEATH <b>4:45 P M</b>			
4. SOCIAL SECURITY NUMBER		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>07/22/16</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>329 Wessling Circle 21228</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Catonsville</b>				9c. COUNTY OF DEATH <b>Baltimore</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Catonsville</b>				10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>329 Wessling Circle</b>				10f. ZIP CODE <b>21228</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Clerk</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Baltimore Business Forms</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Oliver W. Payne</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Emma Meeth</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy V. Payne</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>329 Wessling Circle Catonsville, MD 21228</b>							
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Baltimore National Cem. 2/28</b>		DATE <b>Baltimore, MD</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>George E. MacNabb</b>				22. NAME AND ADDRESS OF FACILITY <b>MacNabb Funeral Home, P.A. 301 Frederick Road Balto., MD 21228</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Colon cancer c lung metastasis</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death <b>1 yr.</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>William C. Waterfield MD</b>				29c. LICENSE NUMBER <b>024356</b>				29d. DATE SIGNED (Month, Day, Year) <b>2/26/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William C. Waterfield St Agnes Hosp 900 Cato Ave Balt 21229</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <b>John S. ...</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94-1020-005  
B.K.S

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06580

1. DECEDENT'S NAME (First, Middle, Last) RUTH ALVERTA PFISTER				2. DATE OF DEATH MONTH DAY YEAR MAR. 1 94		3. TIME OF DEATH 2:07 P M					
4. SOCIAL SECURITY NUMBER 118 42 0037		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-3-18		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) DEVALE AND BIRCH AVENUE				9b. CITY, TOWN OR LOCATION OF DEATH			9c. COUNTY OF DEATH BALTIMORE CO.				
RESIDENCE OF DECEDENT				10a. STATE Maryland		10b. COUNTY Balto Co.		10c. CITY, TOWN OR LOCATION Dundalk			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 86 Yorkway Apt B		10f. ZIP CODE 21222		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES no		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) James Joseph Pfister				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Alverta Covington Shipley							
19a. INFORMANT'S NAME (Type/Print) Mrs Catherine Wright				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 Ivywood Lane, Naples, Florida 33962							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE		20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald Wade, Dir				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St, Balto., MD 21201							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Arteriosclerotic cardiovascular disease</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ROADWAY							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) MAR. 2, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANDIXON 111 Penn Street, Baltimore, Maryland 21201				31. DATE WHEN COMPLETED (Month, Day, Year) MAR 04 1994							
32. REGISTRAR'S SIGNATURE [Signature]											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

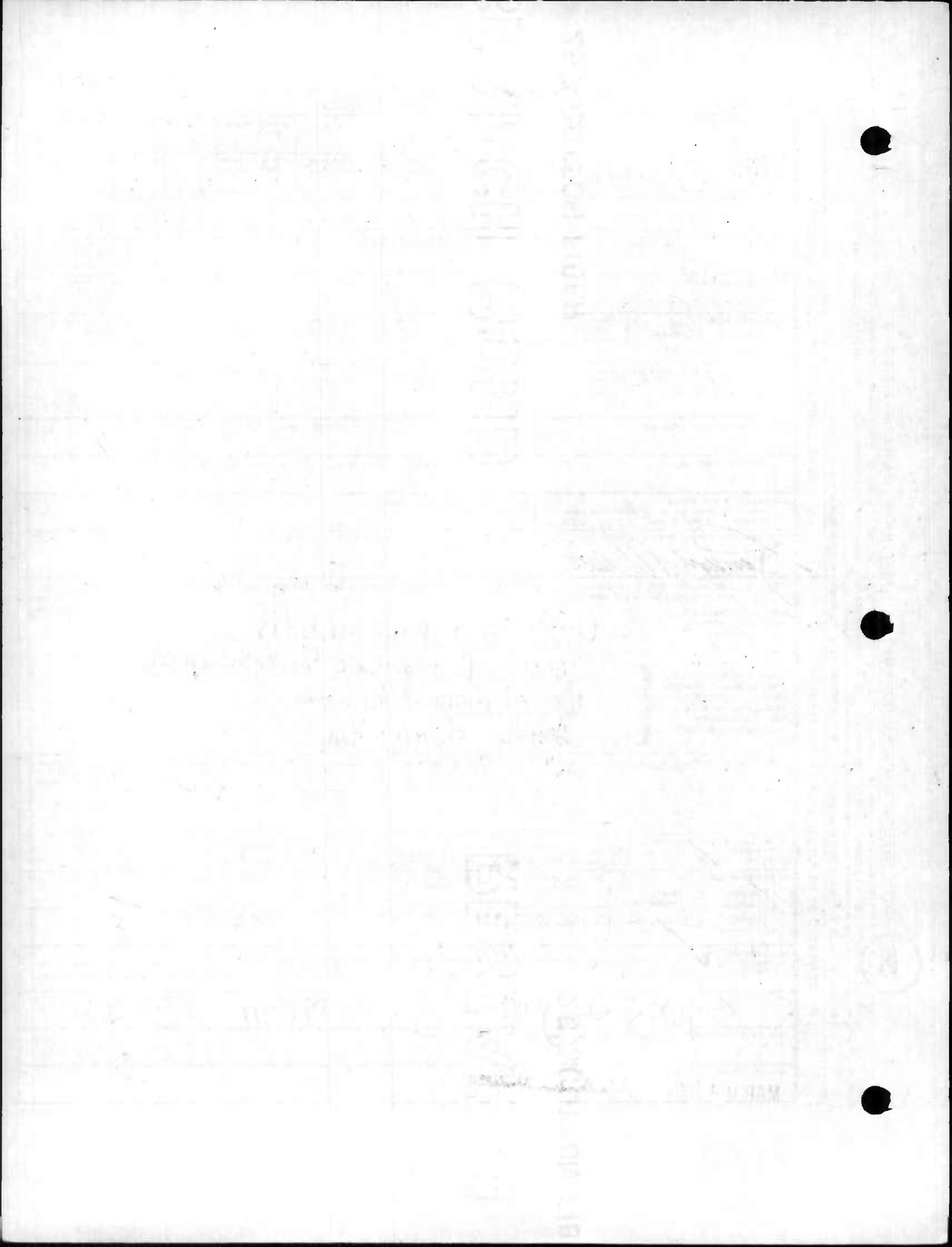


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE										94 06581			
1 - FOR STATE REGISTRAR										REG. NO.			
CERTIFICATE OF DEATH													
1. DECEDENT'S NAME (First, Middle, Last) <b>MARY PEYTON</b>				2. DATE OF DEATH <b>2-27-94</b>				3. TIME OF DEATH <b>7:00 P.M.</b>					
4. SOCIAL SECURITY NUMBER <b>577-22-9596</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>35</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-3-1909</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Bon Secours Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>na</b>					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>na</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>					
10e. STREET AND NUMBER <b>1217 W. Fayette St</b>				10f. ZIP CODE <b>21223</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)									
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state removal</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir</b>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board 655 W. Baltimore St, Balto, MD 21201</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Aspiration pneumonia</b> <b>Severe post-anoxic encephalopathy</b> <b>Hx of Chronic Depression</b> <b>Senile dementia</b>										Approximate Interval Between Onset and Death			
24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>									
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Shorsolen</b>				29c. LICENSE NUMBER <b>D18711</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/28/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendell</b>									





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SARA</b> Sara <b>ROTTMAN</b>				2. DATE OF DEATH MONTH <b>FEB.</b> DAY <b>28</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>5:25 AM</b>	
4. SOCIAL SECURITY NUMBER <b>215-01-4106</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>FEB. 1, 1903</b>	
8. BIRTHPLACE (State or Foreign Country) <b>LITHUANIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>MILFORD MANOR NURSING HOME</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>2500 W. BELVEDERE AVE, APT. 417</b>	
10f. ZIP CODE <b>21215</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>HOUSEWIFE</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>AT HOME</b>	
17. FATHER'S NAME (First, Middle, Last) <b>REUBEN GOTTHELF</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY GARFIELD</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS SYLVIA SKLAR</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>33 TENTMILL LANE, APT. H BALTIMORE, MD 21208</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>RADOMER VEREIN 3-1-94</b>		20c. LOCATION — City or Town, State <b>ROSEDALE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD BALTIMORE, MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CEREBRAL THROMBOSIS</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ALZHEIMER DEMENTIA ATHERO SCLEROTIC HEART DISEASE</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lashleen Jabeen MD</i>				29c. LICENSE NUMBER <b>28595</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/28/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>7220 PARK HEIGHTS AVE BALD MD 21208</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SDS COLLEGE HANDBOOK

DE WITTEH LEONARD

DE WITTEH LEONARD

*[Handwritten signature]*

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06583

1. DECEDENT'S NAME (First, Middle, Last) Josephine M Ranieri				2. DATE OF DEATH MONTH 2 DAY 27 YEAR 94		3. TIME OF DEATH 2:15 M	
4. SOCIAL SECURITY NUMBER 218-09-0478		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 30, 1916	
9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2816 FLEETWOOD AVENUE				10f. ZIP CODE 21214		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY AT HOME			
17. FATHER'S NAME (First, Middle, Last) ORAZIO TROVATO				18. MOTHER'S NAME (First, Middle, Maiden Surname) CONCETTA CANNIZZARO			
19a. INFORMANT'S NAME (Type/Print) CRAIG DUDA				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7820 WARFIELD ROAD LAYTONSVILLE, MD. 20882			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HOLY REDEEMER CEM. 3/3/94		20c. LOCATION — City or Town, State BALTIMORE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Dolan</i> JOHN E. DOLAN				22. NAME AND ADDRESS OF FACILITY LEONARD J. RUCK INC. 5305 HARFORD ROAD BALTIMORE, MD. 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Myelomonocytic leukemia DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis splenic infarction							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ch. B. Miller MD</i> MD				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 2/27/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Union Memorial Hospital Baltimore, MD 21218							
31. DATE FILED (Month, Day, Year) MAR 04 1994				32. REGISTRAR'S SIGNATURE <i>John S. Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the same Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



10



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH  
REG. NO.

94 06584

1. DECEDENT'S NAME (First, Middle, Last) Tilghman Herman Reiblich				2. DATE OF DEATH MONTH 03 DAY 02 YEAR 94		3. TIME OF DEATH 3:45 PM			
4. SOCIAL SECURITY NUMBER 217-16-4054		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1/14/1918		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 3319 Echodale Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			9c. COUNTY OF DEATH		
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 3319 Echodale Avenue				10f. ZIP CODE 21214		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor			16b. KIND OF BUSINESS/INDUSTRY United States Postal Service				
17. FATHER'S NAME (First, Middle, Last) Henry William Reiblich				18. MOTHER'S NAME (First, Middle, Maiden Surname) Agatha Ann Gerken					
19a. INFORMANT'S NAME (Type/Print) Anita C. Reiblich				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3319 Echodale Avenue Baltimore, Md. 21214					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lorraine Park Cemetery 3/5/94		20c. LOCATION — City or Town, State Baltimore, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavoyna				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): b. SEVERE CORONARY ATHEROSCLEROSIS DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Approximate Interval Between Onset and Death ACUTE CHRONIC									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Patient collapsed after shoveling snow	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Duncan Salmon M.D.		29c. LICENSE NUMBER D25733		29d. DATE SIGNED (Month, Day, Year) 3/3/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Duncan Salmon, M.D. 5601 Loch Raven Blvd. (4th Floor)									
31. DATE FILED (Month, Day, Year) MAR 04 1994				32. REGISTRAR'S SIGNATURE J. Duncan Salmon					



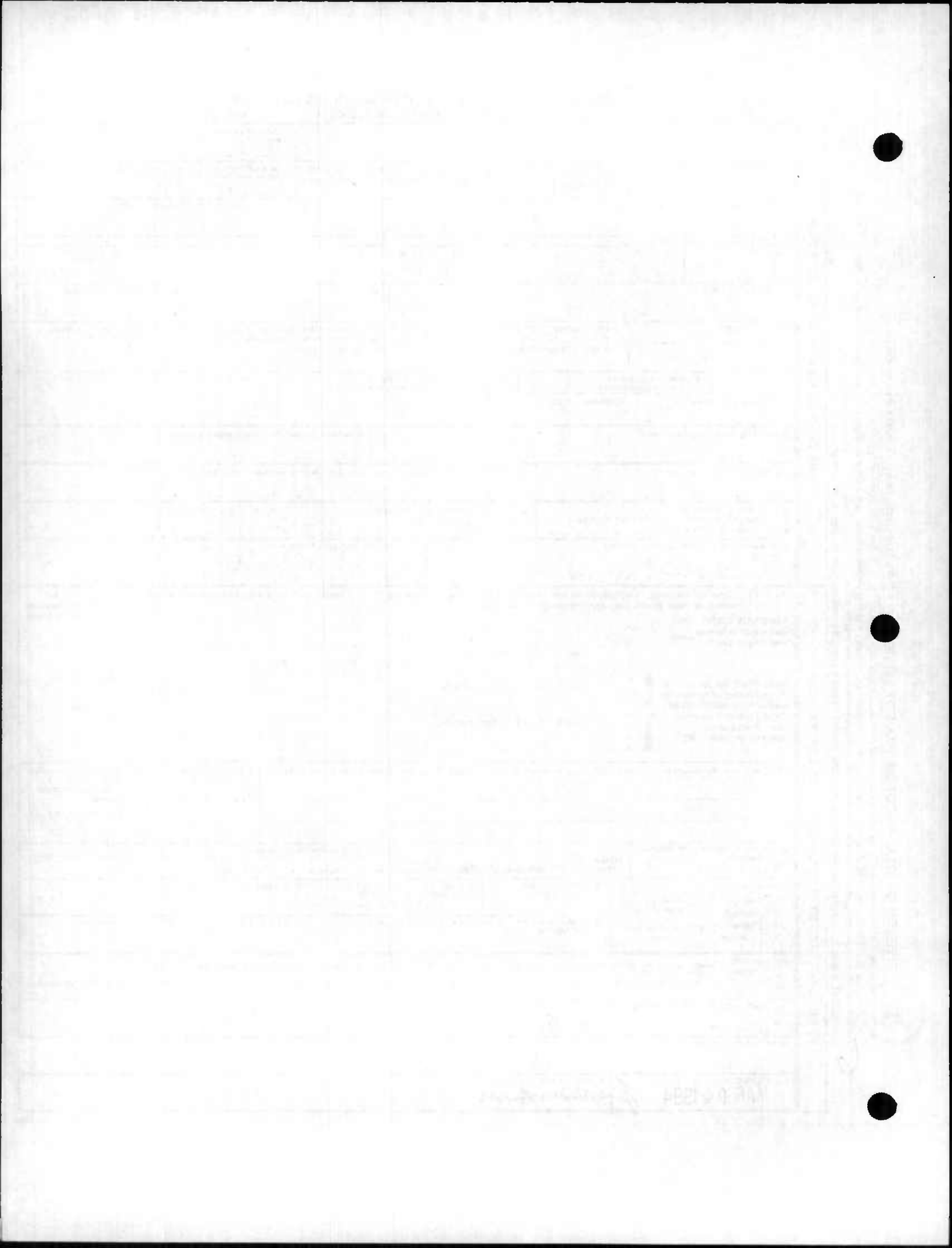
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				94 06585					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) <i>Nina L. Russ</i>				2. DATE OF DEATH MONTH DAY YEAR <i>2-28-1994</i>				3. TIME OF DEATH M <i></i>					
4. SOCIAL SECURITY NUMBER <i>219-20-6301</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>82 YRS.</i>		IF UNDER 1 YEAR MONTHS DAYS <i></i>		IF UNDER 24 HRS. HOURS MIN. <i></i>		7. DATE OF BIRTH (Month, Day, Year) <i>2-7-1912</i>		8. BIRTHPLACE (State or Foreign Country) <i>Massachusetts</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>3134 Woodhome Ave.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>				9c. COUNTY OF DEATH <i>Baltimore</i>					
RESIDENCE OF DECEDENT													
10a. STATE <i>MD</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <i>3134 Woodhome Ave.</i>				10f. ZIP CODE <i>21234</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i></i> College (1-4 or 8+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Seamstress</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Clothing</i>					
17. FATHER'S NAME (First, Middle, Last) <i>John Feldten</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Leonore Bailey</i>									
19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Rose P. Swick</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3134 Woodhome Ave. Balto., Md. 21234</i>									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Greenmount Crematory 3/4 Balto., Md</i>		DATE <i></i>		20c. LOCATION — City or Town, State <i>Balto., Md</i>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Hartley Miller Funeral Home 7527 Hanford Rd. Balto., Md. 21234</i>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>ASCVD</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): <i>DIABETES MELLITUS II</i> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide <input type="checkbox"/> Not determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <i></i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature] M.D.</i>						29c. LICENSE NUMBER <i>D38033</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/2/94</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>IRENE F. ISMAIA 100 N. BROADWAY ST BALTO. MD</i>													
31. DATE FILED (Month, Day, Year) <i>MAR 04 1994</i>						32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06586

1. DECEDENT'S NAME (First, Middle, Last) <b>LENA ROSEN</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>2</b> YEAR <b>94</b>		3. TIME OF DEATH <b>6 05 P M</b>			
4. SOCIAL SECURITY NUMBER <b>015-05-3094</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month/Day/Year) <b>3/14/13</b>		8. BIRTHPLACE (State or Foreign Country) <b>NY</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>I-95 890 Mile Mark</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>I-95 (890 MILE MARK)</b>			9c. COUNTY OF DEATH <b>HARFORD</b>		
RESIDENCE OF DECEDENT									
10a. STATE <b>Florida</b>		10b. COUNTY <b>Broward</b>		10c. CITY, TOWN OR LOCATION <b>Hallandale</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1825 South Ocean Drive</b>				10f. ZIP CODE <b>33020</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>—</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>		
17. FATHER'S NAME (First, Middle, Last) <b>Meyer Goldring</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jennie Schneider</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Bernice Gibbs</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>50 Valley Lane North Woodmere, NY</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Montefiore Cemetery 3-6-94</b>		20c. LOCATION — City or Town, State <b>Laurelton, NY</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Peter S. Aschke M.D.</b>				22. NAME AND ADDRESS OF FACILITY <b>Sterling Ashton Funeral Home 736 Edmondson Ave Baltimore, Maryland 21228</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MULTIPLE INJURIES</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>MULTIPLE INJURIES</b> b. c. d. Approximate Interval Between Onset and Death <b>SUDDEN</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month/Day/Year) <b>3/2/94</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>PASSENGER IN VAN-ROLLED OVER</b>	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HWY I-95; 890 mi. marker</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>HWY I-95</b>							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature] S.M. ALEK</b>		29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month/Day/Year) <b>3/2/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>S.M. ALEK</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

RECORDS

FROM

THE

COLLECTION



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

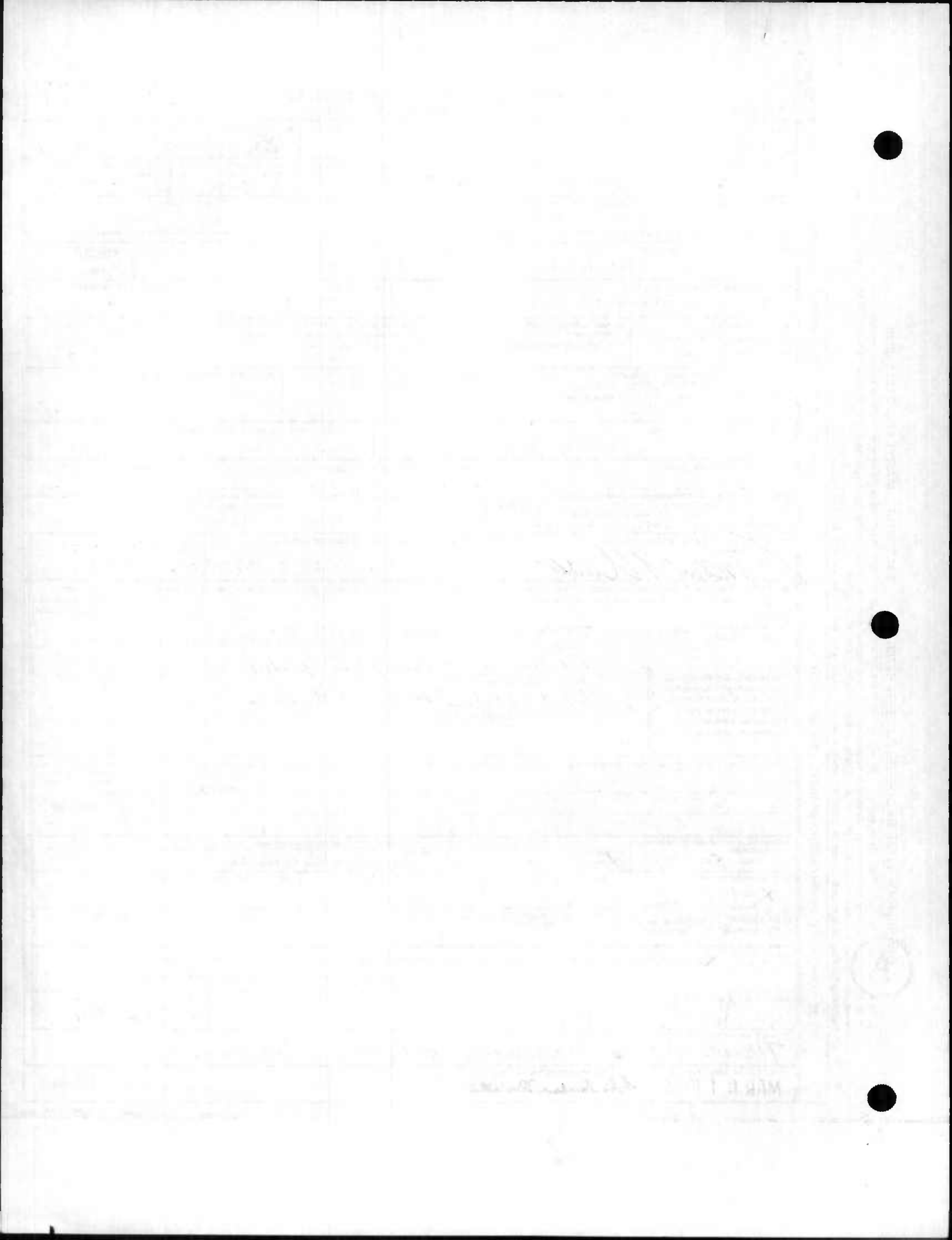
TO THE DEPT. OF HEALTH AND MENTAL HYGIENE: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

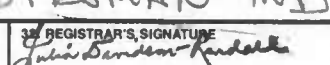
1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				94 06587	
CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <b>EUGENE RUFFNER Eugene Ruffiner</b>		2. DATE OF DEATH MONTH <b>02</b> DAY <b>27</b> YEAR <b>94</b>		3. TIME OF DEATH <b>1455 hrs</b>			
4. SOCIAL SECURITY NUMBER <b>213 34 9821</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-19-1925</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Switzerland</b>		9a. FACILITY NAME (If not institution, give street and number) <b>Harbor Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>na</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>AnneArundelCounty</b>		10c. CITY, TOWN OR LOCATION <b>Glen Burnie</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>#11 4th AvenueSW MailBox 603</b>		10f. ZIP CODE <b>21061</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>No</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chef</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Bernhard Ruffiner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Martha</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Samuel Kristofik</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3831 S. Atlantic Ave, Daytona Beach, FL 32127</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>in state removal</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>DATE</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade</i>		22. NAME AND ADDRESS OF FACILITY <b>State Anatomdy Board 655W. Baltimore St, Balto, MD 21201</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. SEPSIS SEPTIC ARTHRITIS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. GRADE II Encephalopathy</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. End stage liver failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>							
24. Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>2/27/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>THOMAS GEORGE, HARBOR HOSPITAL CENTER BALTIMORE.</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

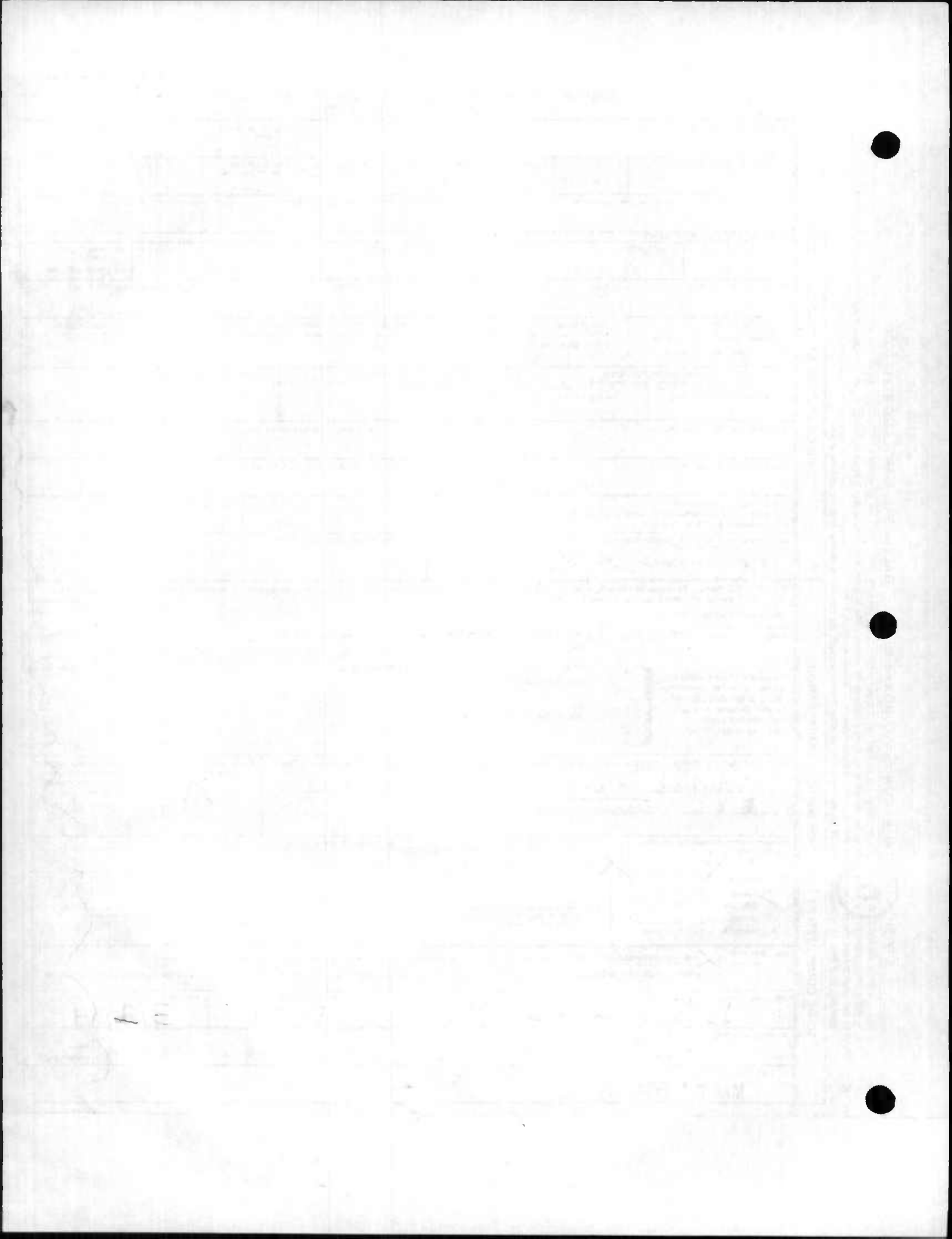


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				94 06588	
CERTIFICATE OF DEATH				REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last) <b>ALFIERA SASS</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>1</b> YEAR <b>1994</b>				3. TIME OF DEATH <b>1:30 a. M</b>	
4. SOCIAL SECURITY NUMBER <b>213-28-4242</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>01-07-26</b>		8. BIRTHPLACE (State or Foreign Country) <b>ITALY</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>CATONSVILLE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>409 LAFAYETTE AVENUE</b>				10f. ZIP CODE <b>21228</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>SEAMSTRESS</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SEAMSTRESS</b>		16b. KIND OF BUSINESS/INDUSTRY <b>DEPARTMENT STORE</b>					
17. FATHER'S NAME (First, Middle, Last) <b>GAGLIARDI</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ESPONINA QUERCI</b>					
19a. INFORMANT'S NAME (Type/Print) <b>FRANK SASS (HUSBAND)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>409 LAFAYETTE AVENUE CATONSVILLE, MARYLAND 21228</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>DRUID RIDGE CEMETERY 03/04/94</b>		20c. LOCATION — City or Town, State <b>PIKESVILLE, MARYLAND</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>LEROY M &amp; RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> a. <b>Cerebral herniation / Cerebral edema</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Glioblastoma Multiforme</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. <b>Approximate Interval Between Onset and Death</b> 15 min 1 month									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>C. difficile colitis</b> <b>E. coli bacteremia</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  <b>MD</b>		29c. LICENSE NUMBER <b>55790</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. S. PEGGMAN MD 600 N. Wolfe ST, JHH, Baltimore</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE 					





TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06589

1. DECEDENT'S NAME (First, Middle, Last) <i>Joseph Anthony Stec, Sr.</i>				2. DATE OF DEATH MONTH <i>2</i> DAY <i>22</i> YEAR <i>1994</i>		3. TIME OF DEATH <i>4:47 PM</i>					
4. SOCIAL SECURITY NUMBER <i>187-12-1673</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>71</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>7/22/1922</i>		8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Francis Scott Key Medical Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>				9c. COUNTY OF DEATH			
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Dundalk</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <i>1709 Ranch Lane</i>				10f. ZIP CODE <i>21222</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>Navy WW II</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (8-12)</i> <i>12th Grade</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Night Shift Manager</i>		15b. KIND OF BUSINESS/INDUSTRY <i>Martin Marietta</i>							
17. FATHER'S NAME (First, Middle, Last) <i>Andrew Stec</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Varosz</i>							
19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Frances M. Stec</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1709 Ranch Lane Dundalk, Maryland 21222</i>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Stanislaus Cem. 2/26/1994</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles W. Lutz</i>				22. NAME AND ADDRESS OF FACILITY <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Arteriosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death <i>0-1 hour</i> <i>Years</i>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>None</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Calvin E. Jones</i> Attending Surgeon				29c. LICENSE NUMBER <i>D6251</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/22/94</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Calvin E. Jones, M.D., 4940 Eastern Avenue, Baltimore, MD 21224</i>											
31. DATE FILED (Month, Day, Year) <i>MAR 04 1994</i>		32. REGISTRAR'S SIGNATURE <i>John S. Anderson</i>									

REVISED BOMBING REFERENCE

ALPHA

SECTION

SECTION

SECTION

SECTION

SECTION

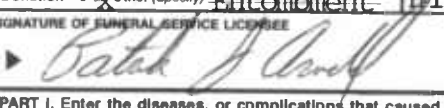
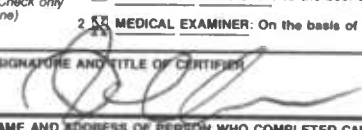
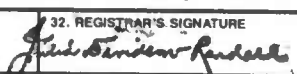
SECTION



94 06590

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SHERRIE LYNN SIMMONS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB. 28, 1994</b>		3. TIME OF DEATH <b>10:00 A.</b>	
4. SOCIAL SECURITY NUMBER <b>214-56-1661</b>		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>44</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Mar. 13, 1949</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>BEL AIR APT 1D</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>	
9c. COUNTY OF DEATH <b>ALLEGANY</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>	
10c. CITY, TOWN OR LOCATION <b>Cumberland</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>Bel Air Apt. 1D</b>	
10f. ZIP CODE <b>21502</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Disabled</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Melvin E. Siegert</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Freida Holman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Christopher Simmons</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt. 1, Box 80A, Burlington, WV 26710</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hillcrest Mausoleum</b>		20c. LOCATION — City or Town, State <b>Annapolis, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ARTERIOSCLEROTIC HEART DISEASE</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>COMPLICATED BY CLOSED HEAD INJURY</b>  Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b> <b>END STAGE RENAL DISEASE</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence 5 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D09157</b>		29d. DATE SIGNED (Month, Day, Year) <b>02/28/1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. PAUL SNOW, DPT MED EX; 125 W 3RD STREET; CUMBERLAND, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

94 06591

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Currean Seales				2. DATE OF DEATH MONTH 3 DAY 1 YEAR 1994		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 219-20-5761		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 96 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-16-1897	
9a. FACILITY NAME (If not institution, give street and number) Inns of Evergreen		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH Va	
RESIDENCE OF DECEDENT							
10a. STATE Md		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 11 W. 20th Street		10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? U S A			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		15b. KIND OF BUSINESS/INDUSTRY Food Services			
17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosa Unknown			
19a. INFORMANT'S NAME (Type/Print) Audrey Q. Harden				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3400 Rosedale Avenue Baltimore, Md			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park 3594		20c. LOCATION — City or Town, State Arbutus, Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bladys Wanner				22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CHRONIC renal failure DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D16961		29d. DATE SIGNED (Month, Day, Year) 3/3/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B COCKMAN 6006 PARK ITIGUO AVE, BALTIMORE MD 21225							
31. DATE FILED (Month, Day, Year) MAR 04 1994				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06592

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Thaddeus Sobolewski</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 2, 1994</b>		3. TIME OF DEATH <b>1:00 PM</b>	
4. SOCIAL SECURITY NUMBER <b>198-05-3357</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 30, 1913</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9. COUNTY OF DEATH <b>Baltimore</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Manor Care Towson</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>			
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Essex</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>1000 Franklin Avenue Apt 905</b>			
10f. ZIP CODE <b>21221</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Glazer</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Glazer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Board of Education</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Sobolewski</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Margaret C. Sobolewski</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Apt 905 1000 Franklin Avenue Essex, Maryland 21221</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem. 3/5/94</b>		20c. LOCATION — City or Town, State <b>Baltimore County, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael C. Gaffan</i>				22. NAME AND ADDRESS OF FACILITY <b>Bruzdzinski Funeral Home PA 1407 Eastern Avenue Essex, Maryland 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>aspiration</b> DUE TO (OR AS A CONSEQUENCE OF):							
{ <b>dementia</b> DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>T. Hawk</i>				29c. LICENSE NUMBER <b>D41104</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-4-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ted Hawk 7825 York Rd Baltimore MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Gordon Elmer Seelhorst</b>				2. DATE OF DEATH MONTH <b>Feb</b> DAY <b>28</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>4:01 A</b> M	
4. SOCIAL SECURITY NUMBER <b>212-10-8663</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 11, 1918</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Middle River</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>3818 New Section Road</b>	
10f. ZIP CODE <b>21220</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b>Truck Driver</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Truck Driver</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Ferdinand Seelhorst</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie Werner</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Daniel Brockmeyer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9772 Matzon Road Baltimore Md. 21221</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. LOCATION — City or Town, State <b>Baltimore Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. Ferry Connelly</i> <b>Connelly Funeral Home</b>				22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home of Essex</b> <b>300 Mace Ave. Baltimore MD. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. arteriosclerotic cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.				Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stanley Z. Felsenberg</i> Deputy Medical Examiner			
29c. LICENSE NUMBER <b>001085</b>				29d. DATE SIGNED (Month, Day, Year) <b>Feb 28, 1994</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>STANLEY Z. Felsenberg MD 11 E. Chicago 21202</b>				31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>			
32. REGISTRAR'S SIGNATURE <i>Julius Benson</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked "Other" on item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





**VOID**

**CERTIFICATE** ✕

94-06594

Sean J. Trueheart  
**SEE** Fetal Death

**CERTIFICATE** ✕

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				94 06595									
CERTIFICATE OF DEATH				REG. NO.													
1. DECEDENT'S NAME (First, Middle, Last) <b>Mary, L. Turczyk</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>3</b> YEAR <b>94</b>				3. TIME OF DEATH <b>11:35 a.m.</b>									
4. SOCIAL SECURITY NUMBER <b>229-10-9140</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS <b>09</b> DAYS <b>03</b>		IF UNDER 24 HRS. HOURS <b>18</b> MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>09 03 18</b>		8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>UNIVERSITY HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b>-</b>									
RESIDENCE OF DECEDENT																	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>GLEN BURNIE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
10e. STREET AND NUMBER <b>131 THOMAS ROAD</b>				10f. ZIP CODE <b>21060</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>				16b. KIND OF BUSINESS/INDUSTRY <b>HOMEMAKER</b>											
17. FATHER'S NAME (First, Middle, Last) <b>JEFFERSON M. VICK</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LELIA LESNER</b>													
19a. INFORMANT'S NAME (Type/Print) <b>MARY JO TURCZYK</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7469F FURNACE BRANCH RD-GLEN BURNIE, MD. 21060</b>													
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GLEN HAVEN CEMETERY 3/7</b>		DATE <b>3/7</b>		20c. LOCATION — City or Town, State <b>GLEN BURNIE, MD.</b>											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Larry L. Kaufman</b>				22. NAME AND ADDRESS OF FACILITY <b>RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.</b>													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Hypertension</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Hypercholesterolemia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death <b>3 days</b> <b>&gt;10yrs</b> <b>&gt;10yrs</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Intracranial Bleed</b>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>N/A</b>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED							
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29b. SIGNATURE AND TITLE OF CERTIFIER <b>John Portelli M.D.</b>		29c. LICENSE NUMBER <b>041527</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John Portelli, 22 S. Greene St. Baltimore MD 21201</b>																	
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <b>John Portelli</b>													



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06596

1. DECEDENT'S NAME (First, Middle, Last) <b>Frances Kathryn Topping</b>			2. DATE OF DEATH MONTH DAY YEAR <b>03/03/94</b> <i>March 3 1994</i>		3. TIME OF DEATH <b>10:16 A M</b>					
4. SOCIAL SECURITY NUMBER <b>579-42-3276</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11/03/19</b>		8. BIRTHPLACE (State or Foreign Country) <b>Massachusetts</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>The Joseph Richey Hospice</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>			9c. COUNTY OF DEATH <b>---</b>			
10a. STATE <b>DC</b>			10b. COUNTY <b>---</b>			10c. CITY, TOWN OR LOCATION <b>Washington</b>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2727 29th Street, NW</b>				10f. ZIP CODE <b>20008</b>			10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>			15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Economic Adviser</b>			15b. KIND OF BUSINESS/INDUSTRY <b>Government &amp; Private Industry</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Samuel Topping</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Frieda (Unknown to Records)</b>						
19a. INFORMANT'S NAME (Type/Print) <b>Ann K. Osman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3940 Deer Park Court Havre de Grace, MD 21078</b>						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 3/4</b>			20c. LOCATION — City or Town, State <b>Baltimore, MD</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George E. MacNabb</i> <b>George E. MacNabb</b>			22. NAME AND ADDRESS OF FACILITY <b>Cremation Society of Md., Inc. 299 Frederick Road Balto., MD 21228</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Endometrial Carcinoma</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b>								Approximate Interval Between Onset and Death <b>18 + 2405</b>		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>24a. WAS AN AUTOPSY PERFORMED?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Hospice</b>							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael G. Hayes, M.D.</i>					29c. LICENSE NUMBER <b>002290</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Michael G. Hayes, M.D. 820 N. Eutaw St. Baltimore, MD 21201</b>										
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>										

BLEED

RECORD

RECORD

RECORD



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

94 06597

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NANCY LEE VANSKIVER				2. DATE OF DEATH MONTH DAY YEAR 02 24 1994		3. TIME OF DEATH 1610 M							
4. SOCIAL SECURITY NUMBER 213-28-7847		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) 04 08 1931		8. BIRTHPLACE (State or Foreign Country) MARYLAND					
9a. FACILITY NAME (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS			9c. COUNTY OF DEATH ANNE ARUNDEL						
RESIDENCE OF DECEDENT				10a. STATE MARYLAND		10b. COUNTY QUEEN ANNE'S		10c. CITY, TOWN OR LOCATION STEVENSVILLE					
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 951 CLOVERFIELDS DRIVE		10f. ZIP CODE 21666		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) NONE		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		15b. KIND OF BUSINESS/INDUSTRY OWN HOME									
17. FATHER'S NAME (First, Middle, Last) PATRICK HERRIGAN				16. MOTHER'S NAME (First, Middle, Maiden Surname) MARY MONTIER									
19a. INFORMANT'S NAME (Type/Print) CHARLES VANSKIVER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 951 CLOVERFIELDS DRIVE, STEVENSVILLE, MD. 21666									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK 2/28/94		20c. LOCATION — City or Town, State GLEN BURNIE, MD.									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Adams				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, SW, GLEN BURNIE, MD. 21061									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Asystole b. Acute Myocardial Infarction c. coronary atherosclerotic heart disease d. generalized atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CABG Diabetes Mellitus End stage renal disease								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER George C. Samaras, M.D.		29c. LICENSE NUMBER D08314		29d. DATE SIGNED (Month, Day, Year) 2/11/94							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George C. Samaras, M.D. 205 Ridgely Avenue Annapolis Md.				31. DATE FILED (Month, Day, Year) MAR 04 1994									
32. REGISTRAR'S SIGNATURE John B. Anderson				21401									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO. 94 06598			
1. DECEDENT'S NAME (First, Middle, Last) Gloria E. Wiltz				2. DATE OF DEATH MONTH 3 DAY 1 YEAR 1994				3. TIME OF DEATH 7:54 P M							
4. SOCIAL SECURITY NUMBER 218-42-3286		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 8-6-1942		8. BIRTHPLACE (State or Foreign Country) Md			
9a. FACILITY NAME (If not institution, give street and number) 1714 Park Avenue Apt 508				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH							
10a. STATE Md		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. CITIZEN OF WHAT COUNTRY? U S A					
10f. STREET AND NUMBER 1714 Park Avenue				10g. ZIP CODE 21217				10h. CITIZEN OF WHAT COUNTRY? U S A							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Counselor		16b. KIND OF BUSINESS/INDUSTRY Treatment Center											
17. FATHER'S NAME (First, Middle, Last) Harold Stanley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Beckett											
19a. INFORMANT'S NAME (Type/Print) Kelli Wiltz				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt 508 1714 Park Avenue Baltimore, Md 21217											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park 3594 Randallstown, Md		20c. LOCATION — City or Town, State											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Gladys Wane				22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic non-small cell lung Cancer to brain Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death 6 months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Matilda H. So, MD		29c. LICENSE NUMBER D26250		29d. DATE SIGNED (Month, Day, Year) ▶ March 3, 1994									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MATILDA H. SO 1447 York Rd, Lutherville, MD 21093.															
31. DATE FILED (Month, Day, Year) MAR 04 1994		32. REGISTRAR'S SIGNATURE John B. ...													



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06599

1. DECEDENT'S NAME (First, Middle, Last) <b>TOBY WEINBLATT</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>27</b> YEAR <b>94</b>		3. TIME OF DEATH <b>3:30 AM</b>	
4. SOCIAL SECURITY NUMBER <b>218-14-6740</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MARCH 4, 1922</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>MD.</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD.</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2732 OLD COURT RD.</b>				10f. ZIP CODE <b>21208</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PSYCHOLOGIST</b>		16b. KIND OF BUSINESS/INDUSTRY <b>PSYCHOLOGY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>LOUIS ANGSTER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BESSIE SILVER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MR. SAMUEL WEINBLATT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2732 OLD COURT RD., BALTO., MD. 21208</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ANSHE EMUNAH-AITZ CHAIM 4/1/94</b>		20c. LOCATION — City or Town, State <b>BALTO., MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Samuel Weinblatt</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD. 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>D.I.C.</b>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
b. <b>Cirrhosis</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Hepatitis C</b> DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Che...</i> <b>D.O.</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>02/27/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Sinai Hospital of Baltimore</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julia...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06600

1. DECEDENT'S NAME (First, Middle, Last) <b>LESTER E. WROTEN</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>7</b> YEAR <b>94</b>		3. TIME OF DEATH <b>22:30</b>	
4. SOCIAL SECURITY NUMBER <b>214-16-9843</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>09 05 15</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SAINT AGNES HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>MARYLAND</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>GLEN BURNIE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>200 FERNDAL ROAD</b>				10f. ZIP CODE <b>21061</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW 11</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 8+) <b>0</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SUPERVISOR</b>		15b. KIND OF BUSINESS/INDUSTRY <b>VEHICLE MANUFACTURING</b>			
17. FATHER'S NAME (First, Middle, Last) <b>DANIEL Z. WROTEN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ALMA E. BREEDEN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ROSE ANTHONY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8236 BAYSIDE DRIVE-PASADENA, Md. 21122</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MEADOWRIDGE CEMETERY 3/5</b>		DATE <b>3/5</b>		20c. LOCATION — City or Town, State <b>ELKRIDGE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Darryl L. Kaufman</i>		22. NAME AND ADDRESS OF FACILITY <b>RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>A R D D</b>							
a. DUE TO (OR AS A CONSEQUENCE OF): <b>Pneumonia</b>							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>spk heart valve replacement, CABG PVD, Rheumatoid Arthritis, CCF wood, chronic A-Fib</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>N/A</b>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>OTTO VILLA, M.D., Ph.D.</i>		29c. LICENSE NUMBER <b>D-76292</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/2/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>OTTO VILLA, M.D., Ph.D.; 900 Caton Rd. Baltimore, MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>		32. REGISTRAR'S SIGNATURE <i>John S. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 94 06601	
1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN LEWIS WEINKAM</b>			2. DATE OF DEATH MONTH <b>Feb</b> DAY <b>28</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>10:43 pm</b>
4. SOCIAL SECURITY NUMBER <b>216-16-3540</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>74</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>May 22, 1919</b>	8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>
9a. FACILITY NAME (If not institution, give street and number) <b>Saint Joseph Hospital</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>		9c. COUNTY OF DEATH <b>Baltimore</b>
RESIDENCE OF DECEDENT					
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Essex</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>2105 Rocky Point Road</b>			10f. ZIP CODE <b>21221</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Ship Yard</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Beth Steel</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John A. Weinkam</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Barbara Hammal</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Veronica A. France</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>324 Poplar Road Baltimore Md. 21221</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holly Hill Cemetery 3/4/94 Baltimore Md.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Connelly Funeral Home</i>		22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CONGESTIVE HEART FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death <b>2 YRS.</b> <b>36 YRS.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>— ATRIAL FIBRILLATION</b>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rose</i> <b>HOUSE STAFF</b>			29c. LICENSE NUMBER <b>D40390</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/1/94</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PANKAJ R. DESAI, M.D., ST. JOSEPH HOSPITAL, 7620 YORK ROAD, TOWSON, MARYLAND 21204</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>		32. REGISTRAR'S SIGNATURE <i>Julia Benson-Randall</i>			





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

94 06602

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FRANK J. ZALESKI</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>04</b> YEAR <b>94</b>		3. TIME OF DEATH <b>0600</b> M	
4. SOCIAL SECURITY NUMBER <b>217-12-6023A</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8-8-23</b> MA	
9a. FACILITY NAME (If not institution, give street and number) <b>CHURCH HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>MARYLAND</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>521 S. MILTON AVENUE</b>				10f. ZIP CODE <b>21224</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 YEARS</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>FENCE AND GATES</b>		16b. KIND OF BUSINESS/INDUSTRY <b>ANCHOR FENCE</b>	
17. FATHER'S NAME (First, Middle, Last) <b>STEPHEN ZALESKI</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY ANNA KOWALSKI</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MR. MILTON ZALESKI</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>521 S. MILTON AVE. BALTO. MD. 21224</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ST. STANISLAUS CEM. 3-7</b>		20c. LOCATION — City or Town, State <b>BALTO. MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>KACZOROWSKI FUNERAL HOME 2525 FLEET STREET BALTO MD. 21224</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ARDS</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal failure</b> <b>Bone marrow failure</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> <b>Med. Specialist</b>				29c. LICENSE NUMBER <b>D40356</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-4-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>W. NAVARRO 100 N. Broadway Balto. MD 21231</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

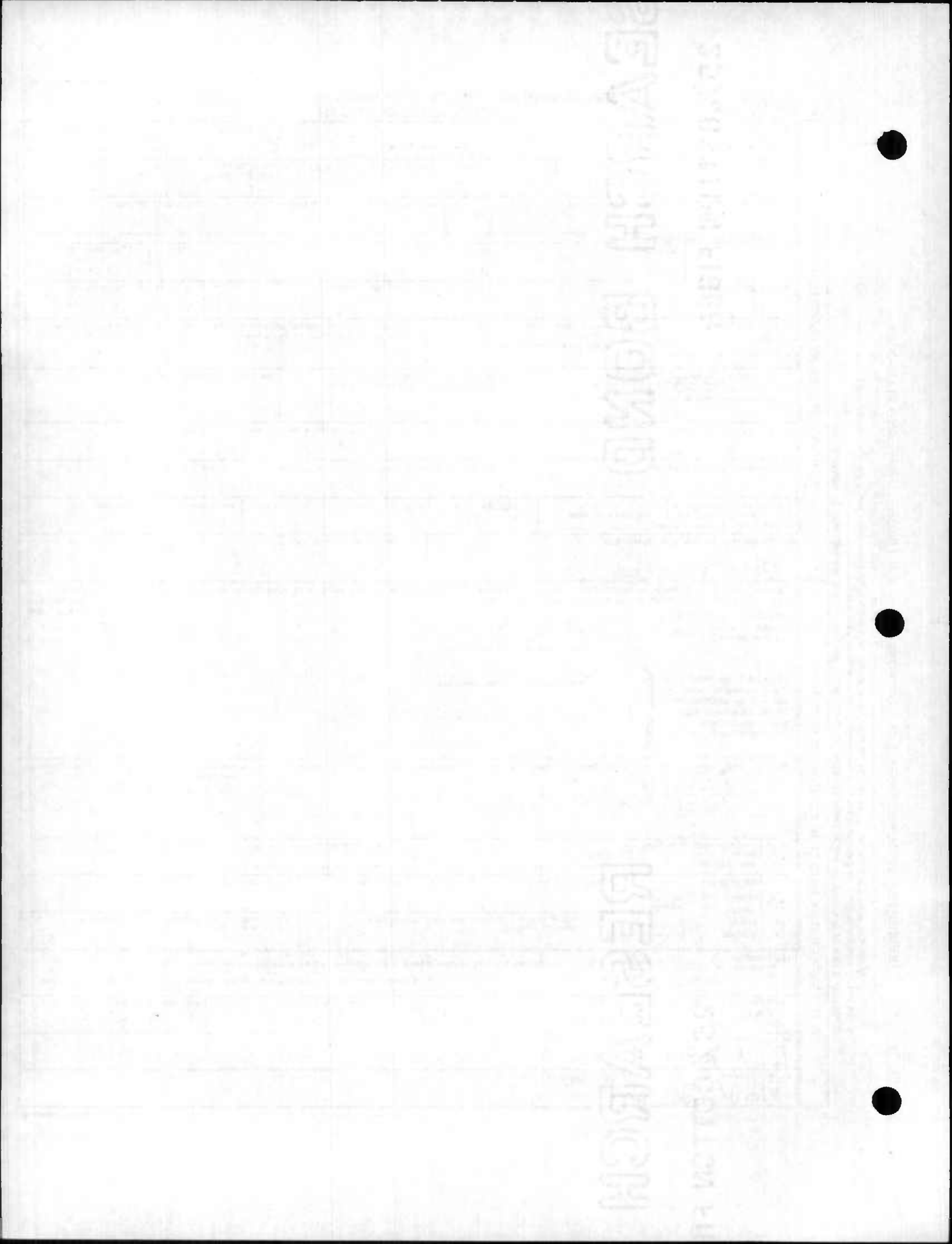
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06603

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles W. Zeigenfuss</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 2, 1994</b>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <b>207 05 7467</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>04/05/13</b>	
8. BIRTHPLACE (State or Foreign Country) <b>PENNSYLVANIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>7308 Heinle Ave.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>							
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7308 Heinle Ave.</b>				10f. ZIP CODE <b>21237</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>===</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SPECIALIZED STEEL MAKING</b>		15b. KIND OF BUSINESS/INDUSTRY <b>ARMCO STEEL</b>			
17. FATHER'S NAME (First, Middle, Last) <b>IRVIN R. ZEIGENFUSE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BARBARA TURA REED</b>			
19a. INFORMANT'S NAME (Type/Print) <b>THAMAH L. ZEIGENFUSE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7308 HEINLE AVE ROSEDALE, MD 21237</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARDENS OF FAITH</b>		DATE <b>3/5</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Cvach/Rosedale Funeral Home 1211 Chesaco Ave.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Meta Static Prostate Carcinoma</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>026835</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Item# 1. Per F.H film G- 709 3/7/94 P.C

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HATTIE Marie Lee ALLEN</b>		2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 03 1994</b>		3. TIME OF DEATH <b>11:41 A</b>	
4. SOCIAL SECURITY NUMBER <b>218-18-9899</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>75</b> YRS.	
6. FACILITY NAME (If not institution, give street and number) <b>MERCY MEDICAL CENTER</b>		7. DATE OF BIRTH (Month, Day, Year) <b>09-25-18</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9b. COUNTY OF DEATH <b>n/a</b>		10a. STATE <b>MARYLAND</b>	
10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1112 BRENTWOOD AVENUE</b>		10f. ZIP CODE <b>21202</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>HIGHSCHOOL</b> College (1-4 or 5+) <b>n/a</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DIETARY AIDE</b>	
17. FATHER'S NAME (First, Middle, Last) <b>SAMUEL L. LEE</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELIZABETH BONDS</b>		19a. INFORMANT'S NAME (Type/Print) <b>CAROLYN ALLEN</b>	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3633 LYNDALE AVENUE, BALTIMORE, MD 21213</b>		20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARBUTUS MEMORIAL PARK 03-09</b>	
20c. LOCATION — City or Town, State <b>ARBUTUS, MARYLAND</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donnette K. Jones</i>		22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH.- 1101 E. NORTH AVENUE</b>	
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>INQUIRY</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J Chute M.D.</i>		29c. LICENSE NUMBER <b>O.C.M.E.</b>	
29d. DATE SIGNED (Month, Day, Year) <b>MARCH 03, 1994</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201</b>		31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>	
32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06605

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Brittany M. Brown</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>02</b> YEAR <b>94</b>		3. TIME OF DEATH <b>0908 AM</b>	
4. SOCIAL SECURITY NUMBER <b>219-23-0496</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>4 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>03-08-89</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>University of Maryland Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Baltimore City</b>	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5101 Williston St.</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (14 or 5+) <b>0</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) <b>N/A</b>		15b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>MICHAEL BROWN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Kimberly WHITLEY</b>			
19a. INFORMANT'S NAME (Type Print) <b>Kimberly WHITLEY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5101 Williston St. Apt 2 Baltimore 21229</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other) <b>KANG MORGUARY PK 3/1/94 Randall Tressler MD</b>		20c. LOCATION — City or Town, State <b>Baltimore MD</b>		20d. DATE <b>3/1/94</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>[Signature]</b>				22. NAME AND ADDRESS OF FUNERAL HOME <b>GARY E. MARCH FUNERAL HOME PA, 270 FRED HILTON PASS 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pancreatitis</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Encephalopathy</b> DUE TO (OR AS A CONSEQUENCE OF): <b>HIV</b> DUE TO (OR AS A CONSEQUENCE OF):  Approximate interval between Onset and Death <b>10 days</b> <b>2 months</b> <b>5 years</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 3 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Randall L. Tressler MD</b>				29c. LICENSE NUMBER <b>D 39702</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/2/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Randall L. Tressler MD, UMMS, 31 S. Greene St. Rm 220 Balto 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT Earl BAKER Sr.</b>				2. DATE OF DEATH MONTH <b>Mar</b> DAY <b>4</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>2:20 PM</b>	
4. SOCIAL SECURITY NUMBER <b>216-20-6741</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb 21, 1927</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Saint Joseph Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5481 Bucknell Road</b>				10f. ZIP CODE <b>21206</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II &amp; Korea</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Gas Supply Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>B.G. &amp; E.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Earl Clayton Baker</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edith Wilson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jean E. Baker</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5481 Bucknell Road Baltimore, Md. 21206</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parkwood Cemetery 3/8/94</b>		20c. LOCATION — City or Town, State <b>Baltimore Maryland</b>		20d. DATE <b>3/8/94</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Milton J. Knight Jr.</i> <b>Milton J. Knight Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>Baltimore, Maryland 21214</b> <b>Leonard J. Ruck, Inc. 5305 Harford Road</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>PNEUMONIA</b>					
		DUE TO (OR AS A CONSEQUENCE OF):					
		b. <b>LUNG CARCINOMA</b>					
		DUE TO (OR AS A CONSEQUENCE OF):					
		c. <b>PANCREATIC CARCINOMA</b>					
		DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PANCREATIC CARCINOMA</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Beatriz P. Dizon M.D.</i> <b>BEATRIZ P. DIZON M.D.</b>				29c. LICENSE NUMBER <b>D16492</b>		29d. DATE SIGNED (Month, Day, Year) <b>Mar. 4, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <b>BEATRIZ P. DIZON M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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94 06607

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Vada Faulkner Brown</b>				2. DATE OF DEATH <b>Mar. 06, 1994</b> YEAR		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>234-34-6121</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH <b>02/25/12</b> MONTH DAY YEAR	
9a. FACILITY NAME (If not institution, give street and number) <b>1115 Freeland Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Freeland</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Freeland</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. ZIP CODE <b>21053</b>		10f. CITIZEN OF WHAT COUNTRY? <b>usa</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>n/a</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>no</b>		14. RACE — American Indian, Black, White, etc. <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>0-8th</b> Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>domestic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>household</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Paris Faulkner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Mays</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Rilla Cantrell</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>737-C Timber Ridge TrVero Beach FL 32962</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, etc.) <b>Meadowridge Memorial Park 3/8</b>		20c. LOCATION — City or Town, State <b>Dorsey, Maryland</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY <b>1328 Sulphur Spring Road, Arbutus, Md</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ovarian cancer</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>037016</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/7/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BENNY B. BROWN Jr</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>2</b> YEAR <b>94</b>		3. TIME OF DEATH <b>6:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>234 107325</b>		5. SEX <b>1</b> M <b>2</b> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-9-16</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MD</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Balto</b>	
10d. INSIDE CITY LIMITS? <b>1</b> YES <b>2</b> NO				10e. STREET AND NUMBER <b>2701 Lannetta Ave</b>		10f. ZIP CODE <b>21223</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>				11. MARITAL STATUS <b>3</b> Widowed <b>4</b> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> YES <b>2</b> NO				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>10th</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) <b>Benny Brown</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary C. B. Smith</b>				19a. INFORMANT'S NAME (Type/Print) <b>Benny Brown</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2701 Lannetta Ave Balto, MD 21223</b>	
20a. METHOD OF DISPOSITION <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest 3/8/94</b>		20c. LOCATION — City or Town, State <b>Dwings Mills, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jerome A. Thompson Jr</b>				22. NAME AND ADDRESS OF FACILITY <b>March F.H. West 4300 Wabash Ave</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>3 days</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <b>1</b> YES <b>2</b> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> YES <b>2</b> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> YES <b>2</b> NO
26. PLACE OF DEATH (Check only one) <b>HOSPITAL:</b> <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA <b>OTHER:</b> <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)				27. MANNER OF DEATH <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> YES <b>2</b> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Chapman D. Tring MD</b>				29c. LICENSE NUMBER <b>AS240321T9990</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/2/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Chapman Tring, M.D. Sinai Hospital of Baltimore</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARK BRYANT</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>4</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>4:31 A</b> M	
4. SOCIAL SECURITY NUMBER <b>212-88-5137</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>32</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-25-61</b>	
8. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION <b>BALTO</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10a. STATE <b>MD</b>		10b. COUNTY		10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10e. STREET AND NUMBER <b>2811 BOARMAN AVE</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+) <b>UNKNOWN</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNKNOWN</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE H. BRYANT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY M. MILLER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GEORGE H. BRYANT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2811 BOARMAN AVE BALTO, MD 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK 3794</b>		20c. LOCATION — City or Town, State <b>RANDALLSTOWN, MD</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sala March</i>				22. NAME AND ADDRESS OF FACILITY <b>MARCH FUNERAL HOME-WEST 4300 WABASH A</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Idiopathic dilated cardiomyopathy</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death <i>30 min</i> <i>8 months</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension, obesity</i>						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jerome Rich MD</i>		29c. LICENSE NUMBER <b>129754</b>	
29d. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Jerome Rich Johns Hopkins Hospital, Tower 110, Balt'm</i>				29e. DATE SIGNED (Month, Day, Year) <b>3/4/94</b>		29f. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>	
32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

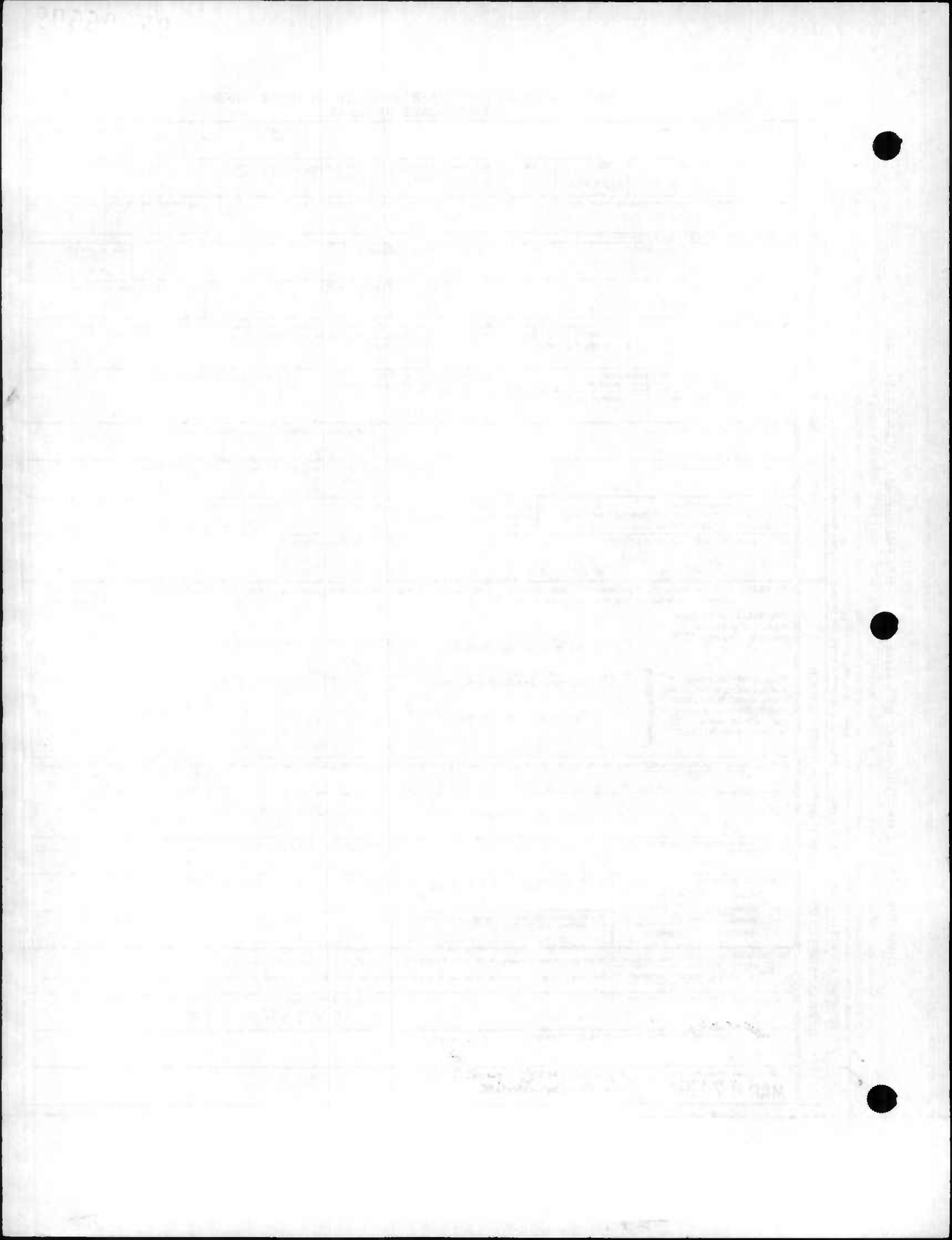
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 06610

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John J. Bezilla				2. DATE OF DEATH MONTH DAY YEAR March 5, 1994		3. TIME OF DEATH 1:20 P.M.	
4. SOCIAL SECURITY NUMBER 068-14-1492		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 6, 1924	
9a. FACILITY NAME (If not institution, give street and number) 1825 Fleet Street				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH -	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY -		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1825 Fleet Street				10f. ZIP CODE 21231		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Special Delivery		16b. KIND OF BUSINESS/INDUSTRY U.S. Postal Service			
17. FATHER'S NAME (First, Middle, Last) Michael Bezilla				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Suhanic			
19a. INFORMANT'S NAME (Type/Print) Rose Bezilla				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1825 Fleet St. Baltimore, Maryland 21231			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem. 3/9		20c. LOCATION — City or Town, State Garrison Forest, Md.		20d. DATE 3/9	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE George A. Weber & Sons Inc.				22. NAME AND ADDRESS OF FACILITY George A. Weber & Sons Inc. 705 S. Ann St. Balto. Md. 21231			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER 024276		29d. DATE SIGNED (Month, Day, Year) 3.7.94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Simon V. Scalia, M.D. 2900 E. Baltimore, St. Balto. Md. 21224							
31. DATE FILED (Month, Day, Year) MAR 07 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>June M. Coleman</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Mar. 2, 1994</b>		3. TIME OF DEATH <b>4:30 P. M</b>	
4. SOCIAL SECURITY NUMBER <b>212-30-4727</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>60</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 5, 1933</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>3591 Half Moon Glen</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Pasadena</b>	
9c. COUNTY OF DEATH <b>Anne Arundel</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Glen Burnie</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>7900 Bennesch Circle Apt. 805</b>	
10f. ZIP CODE <b>21060</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 yrs.</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Billing Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Trucking Industry</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Richards</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lena Meertens</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Diana S. Babb</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3591 Half Moon Glen Pasadena, MD 21122</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glen Haven Memorial Park 3/5/94</b>		20c. LOCATION — City or Town, State <b>Glen Burnie, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Kirkley-Ruddick Funeral Home</b> <b>421 Crain Hwy. S.E. Glen Burnie, MD 21061</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <i>Signature of Heart Failure</i> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> <i>Problem: and Rheumatoid Arthritis pathy</i> <b>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b> <i>End Stage Chronic Pulmonary Disease</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <b>D 15860</b>	
29d. DATE SIGNED (Month, Day, Year) <b>3-7-94</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Hilary O'Herlihy 325 Hospital Drive Glen Burnie, MD 21061</b>			
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MAGGIE WILLIE CHEEK</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAR 05 94</b>		3. TIME OF DEATH <b>11:52 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>239 32 9883</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>APRIL 4, 1923</b>	
8. BIRTHPLACE (State or Foreign Country) <b>NORTH CAROLINA</b>				9. COUNTY OF DEATH			
9a. FACILITY NAME (If not institution, give street and number) <b>2733 CARVER ROAD</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2733 CARVER ROAD</b>				10f. ZIP CODE <b>21225</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S. OF A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>NURSE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOSPITAL</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ARTHUR DOCKERY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LELA MONROE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MR. RONNIE CHEEK</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2339 MADISON AVENUE BALTO., MD. 21217</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory 3/7/94</b>		20c. LOCATION — City or Town, State <b>CATONSVILLE, MARYLAND</b>		20d. DATE <b>3/7/94</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lewis T. Gwynn</i> <b>LEWIS T. GWYNN</b>				22. NAME AND ADDRESS OF FACILITY <b>LEWIS T. GWYNN FUNERAL HOME 21215 4517 PARK HEIGHTS AVE. BALTO., MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO <b>Inquiry</b>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario F. Golle Jr.</i> <b>Mario F. Golle Jr.</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAR 06, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Mario F. Golle Jr. M.D. 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>GORTES Maria V. Maria V. Cortes</i>				2. DATE OF DEATH MONTH DAY YEAR <i>03 03 94</i>		3. TIME OF DEATH <i>5:09 AM</i>	
4. SOCIAL SECURITY NUMBER <i>215-86-8127</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>28</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>11-30-1965</i>	
9a. FACILITY NAME (If not Institution, give street and number) <i>ST Agnes Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Balto</i>		9c. COUNTY OF DEATH <i>Md</i>	
10a. STATE <i>Md</i>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>Balto</i>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <i>4811 Fernley Sq</i>				10f. ZIP CODE <i>21227</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10th</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <i>Victor Cortes</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Eleanor Carroll</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Debra Bright</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4811 Fernley Square Balto, Md 21227</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>King Mem Park 3/1/94</i>		20c. LOCATION — City or Town, State <i>Randallstown, Md</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale March</i>				22. NAME AND ADDRESS OF FACILITY <i>March F.H. West 4300 Wabash Ave</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Respiratory Insufficiency</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. Bronchopneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c. AIDS</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d.</i>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert R. G. 1</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>03/03/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <i>Saint Agnes Hospital - 600 N. ...</i>							
31. DATE FILED (Month, Day, Year) <i>03/07/94</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

DMMH-16 Rev 1/89

**HOW TO USE THIS FORM:** DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BEATRICE M CRAWLEY</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>01</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>6 A M</b>	
4. SOCIAL SECURITY NUMBER <b>218-03-2690</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-18-1916</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>DEATON Nursing Home</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		8c. COUNTY OF DEATH <b>N.C.</b>	
9. RESIDENCE OF DECEDENT				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>739 George Street</b>				10f. ZIP CODE <b>21201</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Robert James Douglas</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dillie Wamble</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Vera Hunt</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>739 George St. Baltimore Md. 21201</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of facility, crematory or other place) <b>Garrison Forest Ch. Cem 3/7</b>		20c. LOCATION — City or Town, State <b>Balto. Co. Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph J. Russ</b>				22. NAME AND ADDRESS OF FACILITY <b>Joseph J. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>POSSIBLE MYOCARDIAL INFARCT.</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>CORONARY ARTERY DISEASE</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <b>VENTILATOR DEPENDENT</b>							
Approximate Interval Between Onset and Death							
10 YEARS							
20 YEARS							
6 MONTH							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
<b>HYPERTENSION -</b>							
<b>PULMONARY TUBERCULOSIS -</b>							
<b>LEFT THORACOTOMY</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature] MD</b>				29c. LICENSE NUMBER <b>D37233</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 01, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOSEPH HUBAYKAR - DEATON HOSPITAL</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO

LIBRARY

1000

1000



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JULIET CABBAGESTALK</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>04</b> YEAR <b>94</b>		3. TIME OF DEATH <b>0545A</b> M	
4. SOCIAL SECURITY NUMBER <b>157-14-3782</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>07/24/20</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Md.</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>220 Mt. Holly St.</b>		10f. ZIP CODE <b>21229</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7 th</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laundress</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Laundry</b>	
17. FATHER'S NAME (First, Middle, Last) <b>EUGENE JULIUS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LUCILLE JENNINGS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. FRANCES JOHNSON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>220 MT. HOLLY ST. BALTO. MD. 21229</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State <b>SOUTH CAROLINA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Derrick C. Jones F.H. 4611 Park Heights Ave. Balto., Md. 15</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>RESPIRATORY FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>PULMONARY THROMBOEMBOLISM</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>MULTIORGAN FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF):							
d. <b>CIRRHOSIS OF THE LIVER</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACUTE RENAL FAILURE, INSULIN DEPENDENT DIABETES MELLITUS, HYPERTENSION, PEPTIC ULCER DISEASE, HEPATIC ENCEPHALOPATHY.</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D43453</b>		29d. DATE SIGNED (Month, Day, Year) <b>03/04/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>V. DIXON KING, M.D. ST. AGNES HOSPITAL 900 S. CATON AVENUE BALTO., MD. 21229</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>James Durbin James Orville Durbin</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>2</b> YEAR <b>94</b>		3. TIME OF DEATH <b>2:20 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>174-12-0125</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-11-1917</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Francis Scott Key Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Dundalk</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>2051 Jasmine Road</b>	
10f. ZIP CODE <b>21222</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12th Grade</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Pipefitter Foreman</b>				16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Coast Guard Yard</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Harry Durbin</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ethel Murphy</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Donna Durbin</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2051 Jasmine Road Dundalk, Maryland 21222</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery 3/5/1994</b>			
20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Johnny L. Gibb</b>			
22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. anoxic encephalopathy</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. ventricular arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  <b>c. anemia</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>d.</b> DUE TO (OR AS A CONSEQUENCE OF):			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>3/5/1994</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>J. L. Gibb, physician</b>				29c. LICENSE NUMBER <b>D45059</b>			
29d. DATE SIGNED (Month, Day, Year) <b>3/2/94</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Helen Barola Francis Scott Key</b>			
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician, and the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MILDRED Willie DUNCAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 3 1994</b>		3. TIME OF DEATH <b>638A</b>	
4. SOCIAL SECURITY NUMBER <b>220-24-8864</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>86</b> YRS.	7. DATE OF BIRTH MONTH DAY YEAR <b>Nov 7, 1907</b>		8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Good Samaritan Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Parkville</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8410 Harris Avenue</b>				10f. ZIP CODE <b>21234</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Ulysses Simpson Meadows</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Elizabeth Runyan</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Paul T. Duncan</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>698 Running Bear Ct. Winter Springs, Fla. 32708</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Moreland Memorial 3/7/94</b>		20c. LOCATION — City or Town, State <b>Baltimore Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Milton J. Knight Jr</b>				22. NAME AND ADDRESS OF FACILITY <b>Baltimore, Md. 21214 Leonard J. Ruck, Inc. 5305 Harford Road</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
a. <b>SEPTIC SHOCK</b> DUE TO (OR AS A CONSEQUENCE OF):							<b>2 DAYS</b>
b. <b>PERFORATED BOWEL</b> DUE TO (OR AS A CONSEQUENCE OF):							<b>2 DAYS</b>
c. <b>COLECTOMY</b> DUE TO (OR AS A CONSEQUENCE OF):							<b>6 DAYS</b>
d. <b>LOWER INTESTINAL BLEED</b>							<b>10 DAYS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>BREAST CANCER HYPERTENSION HYPOTHYROIDISM</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Gabriel N. Nazareno MD</b>				29c. LICENSE NUMBER <b>P07617</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAR 3, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GABRIEL NAZARENO 5601 L. RAVEN BLVD, BALDMORE, MD 21239</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEMS: 23 PART I, II, 27, PER MEO FILM G-709:3/17/94 t.t

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Preston J. Davis SR</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>5</b> YEAR <b>94</b>		3. TIME OF DEATH <b>7:17A M</b>	
4. SOCIAL SECURITY NUMBER <b>215-60-1067</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>42</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11/6/51</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>2548 LAURETTA AVE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>MD</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2411 Lexington Street</b>				10f. ZIP CODE <b>21223</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Afro American</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Self Employer</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Labor</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Preston J Davis</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mable Baker</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Preston J Davis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2411 W. Lexington Street 21223</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>King Mem PK</b>		20c. LOCATION — City or Town, State <b>Randalltown, MD</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>[Signature]</b>				22. NAME AND ADDRESS OF FACILITY <b>Sett Miller # 14 1639 W. Broadway</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. <b>ACUTE BRONCHOPNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dennis J. Chuteam</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-5-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 Penn Street, Balto, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DOROTHY M. DORSEY</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>5</b> YEAR <b>74</b>		3. TIME OF DEATH <b>2:35 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>214-22-3002</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8-7-1924</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Md.</b>			
10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>740 Poplar Groove St.</b>			
10f. ZIP CODE <b>21216</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>7th</b> Elementary/Secondary (0-12) <b>College</b> (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Receptionist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Clerical</b>	
17. FATHER'S NAME (First, Middle, Last) <b>James Mumford</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Missouri Means</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Thelma Brown</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>500 Charing Cross Rd. Balto., Md. 21229</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forrest Vet. 3-9</b>		20c. LOCATION — City or Town, State <b>Garrison, Maryland</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY <b>Derrick C. Jones F.H.</b> <b>4611 Park Heights Ave. Balto. Md. 15</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>End stage Chronic obstructive lung disease &gt; 10 yrs</b> DUE TO (OR AS A CONSEQUENCE OF): <b>CHRONIC RENAL FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>DIABETES</b> DUE TO (OR AS A CONSEQUENCE OF): <b>HYPERTENSION</b>					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>MEDICAL RESIDENT</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BARAKAT K. HASSIB, 900 CATON Ave. Baltimore MD 21229</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b> 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SEBASTIAN C. ECHARTE				2. DATE OF DEATH MONTH DAY YEAR FEB. 27 94		3. TIME OF DEATH 8:10 A M					
4. SOCIAL SECURITY NUMBER 149-70-9324		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 42 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01-20-52		8. BIRTHPLACE (State or Foreign Country) CUBA			
9a. FACILITY NAME (If not institution, give street and number) 1102 SOUTH ROBINSON STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			9c. COUNTY OF DEATH n/a				
RESIDENCE OF DECEDENT				10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 1102 S. ROBINSON STREET		10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? CUBA			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: CUBAN		14. RACE — American Indian, Black, White, etc. Specify: BLACK					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 TH College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY RESTAURANT					
17. FATHER'S NAME (First, Middle, Last) n/a				18. MOTHER'S NAME (First, Middle, Maiden Surname) ECHARTE COCA							
19a. INHAZEL FONSECA				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 E. 28 TH STREET, BALTIMORE, MD 21218							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) voshell memorial 03-05		20c. LOCATION — City or Town, State DUNDALK, MARYLAND							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bernard D. Johnson				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.- 1101 E. NORTH AVENUE							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → NEW INJURY DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 2-27-94		28b. TIME OF INJURY UNKNOWN		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED FELL DOWN THE STAIRS			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) AT HOME				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1102 S. ROBINSON ST BALTIMORE MD 21224							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER John P. O'Connell				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) FEB. 27, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. D. Johnson 111 PENN STREET, BALTIMORE, MARYLAND 21201											
31. DATE FILED (Month, Day, Year) MAR 07 1994				32. REGISTRAR'S SIGNATURE John P. O'Connell							

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HENRY SHELTON EARP Jr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>03 04 1994</b>		3. TIME OF DEATH <b>04:15 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>215-01-8244</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>November 18, 1911</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Greater Baltimore Medical Center</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		8c. COUNTY OF DEATH <b>Balto.</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Balto.</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore, Maryland</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6524 Montrose Ave.</b>				10f. ZIP CODE <b>21212</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Vice Pres.</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Radio Station</b>			
17. FATHER'S NAME (First, Middle, Last) <b>H. Shelton Earp, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maude Richardson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Pamela Young</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12827 Folly Quarter Rd. Ellicott City, Md. 21042</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Druid Ridge Cemetery 3/7/94</b>		20c. LOCATION — City or Town, State <b>Pikesville, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>1050 York Rd. 21204 Ruck Towson Funeral Home, Inc.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> a. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Aspiration</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ISCHEMIC HEART DISEASE</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>A 0561</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/8/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James H. Davidson, Jr. 2401 Oslen Dr Balto Md 21204</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Florence A Earnst</b>				2. DATE OF DEATH MONTH DAY YEAR <b>03 04 94</b>		3. TIME OF DEATH <b>7:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>219-16-9070</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4/21/08</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>FRANKLIN SQUARE Hosp.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE MD</b>		9c. COUNTY OF DEATH <b>4-5A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1000 Franklin Ave Apt #1014</b>				10f. ZIP CODE <b>21222</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>—</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>File Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S.F. &amp; G.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>HARRY KNABE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Minnie Jones</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CLARA E. LAMGIE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>415 S. PULASKI Street Balto. Md 21223</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LODGE PARK Cemetery</b>		20c. LOCATION — City or Town, State <b>Balto. Maryland</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charles Bannan</b>				22. NAME AND ADDRESS OF FACILITY <b>Joseph N. Zannino Jr. Funeral Home 263 S. Conkling ST. Balto. Md. 21224</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>Asystole</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
b. <b>Myocardial Infarction</b>							
c. <b>Coronary Thrombosis</b>							
d. <b>Coronary Atherosclerosis</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>3/3/94</b>		28b. TIME OF INJURY <b>02:15 A M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>Natural Cause.</b>				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Joel Gellman MD</b>				29c. LICENSE NUMBER <b>044660</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOEL GELLMAN MD. Franklin Square Hospital Baltimore MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician in the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

203 N. Commercial St. Chicago, Ill. 60610

MAR 9 1974

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY MABEL ENGLE				2. DATE OF DEATH MONTH DAY YEAR February 28, 1994		3. TIME OF DEATH 11:35 P M	
4. SOCIAL SECURITY NUMBER 215-34-2175		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 21, 1904	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not Institution, give street and number) Stella Maris Hospice		9b. CITY, TOWN OR LOCATION OF DEATH Towson	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland			
10b. COUNTY				10c. CITY, TOWN OR LOCATION Baltimore City			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 341 Homeland Southway			
10f. ZIP CODE 21212				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager		16b. KIND OF BUSINESS/INDUSTRY Fair Lanes			
17. FATHER'S NAME (First, Middle, Last) Michael Shannon				18. MOTHER'S NAME (First, Middle, Maiden Surname) Octavia			
19a. INFORMANT'S NAME (Type/Print) Jacqueline Funk				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 341 Homeland Southway Baltimore, Maryland 21212			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial Park 3-3		20c. LOCATION — City or Town, State Baltimore, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE George J. Ferrarse	
22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Recurrent strokes a. DUE TO (OR AS A CONSEQUENCE OF): Cerebrovascular disease b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOR OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER 175504		29d. DATE SIGNED (Month, Day, Year) 3/3/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) E. McKee, M.D. 2300 Edgemoor Rd 21204							
31. DATE FILED (Month, Day, Year) MAR 07 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FRITTS, MILLARD E</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>5</b> YEAR <b>94</b>		3. TIME OF DEATH <b>1:50 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>215 12 1232</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>95</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06 16 98</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Francis Scott Key Medical Center</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		8c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Colgate</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7755 East Baltimore Street</b>				10f. ZIP CODE <b>21224</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chauffeur</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Cab Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Ezekiel Fritts</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ollie Amelia Derry</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dorothea A. Fritts</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7755 E. Balto., St. Balto., Md. 21224</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>		DATE <b>3-8-94</b>		20c. LOCATION — City or Town, State <b>Eastwood, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charles S. Zeiler</b>				22. NAME AND ADDRESS OF FACILITY <b>Charles S. Zeiler &amp; Son Inc. 6224 Eastern Avenue</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Herpetic Encephalitis (Zoster/Varicella)</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Mark S. Winfrey, MD</b>				29c. LICENSE NUMBER <b>94022</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/5/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARK WINFREY MD 141 E MONUMENT ST BALTIMORE MD 21202</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <b>John S. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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APR 10 1964



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DANIEL L. FOARD</b>				2. DATE OF DEATH MONTH <b>Mar</b> DAY <b>6</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>1:40 pm</b>	
4. SOCIAL SECURITY NUMBER <b>212-40-6544</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>53</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 30, 1940</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Saint Joseph Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4532 Ambermill Road</b>				10f. ZIP CODE <b>21236</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1959-9161</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Vice President</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Legg Mason</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Leo J. Foard</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marie A. Foard</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Suzanne Foard (wife)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4532 Ambermill Rd., Baltimore, MD 21236</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith Cemetery 3/9</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CEREBROVASCULAR ACCIDENT</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <b>CAROTID ARTERY DISEASE</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CORONARY ARTERY DISEASE</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>MD</b>				29c. LICENSE NUMBER <b>D29306</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/5/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A.P. ZALDUONDO, M.D., 7620 YORK RD. TOWSON, MD. 21204</b>							
31. DATE-FIELD (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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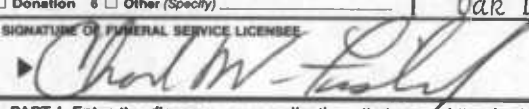
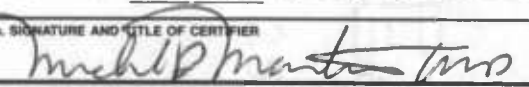
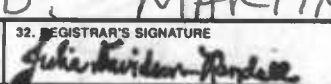
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Robert Edward Fitzgerald</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>3</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>8:07 A M</b>	
4. SOCIAL SECURITY NUMBER <b>253-09-7922</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-18-1916</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>		9c. COUNTY OF DEATH <b>Tennessee</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Dundalk</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8203 Guntree Drive</b>				10f. ZIP CODE <b>21222</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12th Grade</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Insurance Agent</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Life Insurance</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Unknown Fitzgerald</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Terry R. Fitzgerald</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8203 Guntree Drive Dundalk, Maryland 21222</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery 3/5/1994</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>		22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Dehydration, Starvation</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. <b>Lung Cancer</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ASCVD</b> <b>COPD</b> <b>Urinary tract infection</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE NOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D41968</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MICHAEL D. MARTIN</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH REG NO.

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Janie Liggins Freeland</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>2</b> YEAR <b>94</b>				3. TIME OF DEATH <b>4:34 A</b>	
4. SOCIAL SECURITY NUMBER <b>212 56 4244</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>68</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	7. DATE OF BIRTH (Month, Day, Year) <b>6/28/25</b>		8. BIRTHPLACE (State or Foreign Country) <b>S.C.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE <b>Md.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6114 Marquette Rd.</b>				10f. ZIP CODE <b>21206</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Martin Weldon</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Caroline Bailey</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Marian Long</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4918 Crenshaw Ave. Balto., Md.</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus</b>		DATE <b>3/7</b>		20c. LOCATION — City or Town, State <b>Balto., Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i>				22. NAME AND ADDRESS OF FACILITY <b>James A. Morton &amp; Sons</b> <b>1701 Laurens St. Balto., Md. 21217</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Probable Pulmonary Embolus</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>b. Thromboembolic disease</b> <b>c.</b> <b>d.</b>								Approximate interval Between Onset and Death <b>5 hours</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO BY ER				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>Sinai Hospital</b> <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Barry D. Stein MD</i>				29c. LICENSE NUMBER <b>D35408</b>		29d. DATE SIGNED (Month, Day, Year) <b>03/02/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BARRY D. STEIN MD Dept of Rehab Medicine Sinai Hospital Balto, Md 21215</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director, and pages 4 and 6 should be retained within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Pearline Felder</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>2</b> YEAR <b>94</b>		3. TIME OF DEATH <b>1:45 AM</b>	
4. SOCIAL SECURITY NUMBER <b>249-62-1146</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7/16/1906</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Lorien Rehab / NSG Hm.</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia, Md.</b>		8c. COUNTY OF DEATH <b>Howard</b>	
9a. STATE <b>Maryland</b>		9b. COUNTY <b>Howard</b>		9c. CITY, TOWN OR LOCATION <b>Columbia</b>		9d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10a. STREET AND NUMBER <b>5285 Riverdell Lane</b>				10b. ZIP CODE <b>21044</b>		10c. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (13-16) <input checked="" type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Easton H. Felder</b>				18. MOTHER'S NAME (First, Middle, Maiden Name) <b>Rosanna Russell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Mary Fortner</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5285 Riverdell Lane Columbia Md 21044</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Andrew Chapel Baptist Chm 79</b>		20c. LOCATION — City or Town, State <b>South Carolina</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph L. Russ</b>				22. NAME AND ADDRESS OF FACILITY <b>Joseph L. Russ Funeral Home 2252 W. North Ave. Balt. Md 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>ALZHEIMER DEMENTIA</b> b. <b>ALZHEIMER DEMENTIA</b> c. <b>ALZHEIMER DEMENTIA</b> d. <b>ALZHEIMER DEMENTIA</b>							Approximate interval between Onset and Death <b>Days</b> <b>Years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>022856</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-3-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. L. Levinger, 11055 Little House Pkwy, Columbia, Md.</b>							
31. DATE OF DEATH <b>MAR 07 1994</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Gladden, Baby Girl (Jana Shiree)</b>				2. DATE OF DEATH <b>2-28-94</b> MONTH DAY YEAR		3. TIME OF DEATH <b>5:15 A.M.</b>													
4. SOCIAL SECURITY NUMBER		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS HOURS MIN. <b>4 43</b>		7. DATE OF BIRTH (Month, Day, Year) <b>2-28-94</b>													
8a. FACILITY NAME (If not institution, give street and number) <b>Harford Memorial Hospital</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Harford</b>		8c. COUNTY OF DEATH <b>Maryland</b>													
RESIDENCE OF DECEDENT																			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford Co</b>		10c. CITY, TOWN OR LOCATION <b>Edgewood</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO													
10e. STREET AND NUMBER <b>1916 Southridge Drive</b>				10f. ZIP CODE <b>21040</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>													
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>													
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 6+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY													
17. FATHER'S NAME (First, Middle, Last) <b>Kevin O'Brian Gladden</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jennifer Inez EPPSGladden</b>															
19a. INFORMANT'S NAME (Type/Print) <b>Jennifer Gladden</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1916 Southridge Drive, Edgewood, MD 21040</b>															
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State													
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Director</b> <i>ANATOMY BOARD</i>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board</b> <b>655W. Baltimore ST, Balto, MD 21201</b>															
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio respiratory failure.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <table border="0"> <tr> <td>a.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td></td> </tr> <tr> <td>b.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>Acidosis, respiratory</b></td> </tr> <tr> <td>c.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>Extreme low birth weight (VLBW)</b></td> </tr> <tr> <td>d.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>Prematurity.</b></td> </tr> </table>								a.	DUE TO (OR AS A CONSEQUENCE OF):		b.	DUE TO (OR AS A CONSEQUENCE OF):	<b>Acidosis, respiratory</b>	c.	DUE TO (OR AS A CONSEQUENCE OF):	<b>Extreme low birth weight (VLBW)</b>	d.	DUE TO (OR AS A CONSEQUENCE OF):	<b>Prematurity.</b>
a.	DUE TO (OR AS A CONSEQUENCE OF):																		
b.	DUE TO (OR AS A CONSEQUENCE OF):	<b>Acidosis, respiratory</b>																	
c.	DUE TO (OR AS A CONSEQUENCE OF):	<b>Extreme low birth weight (VLBW)</b>																	
d.	DUE TO (OR AS A CONSEQUENCE OF):	<b>Prematurity.</b>																	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>VLBW</b>																			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO																	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO													
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)															
29. LOCATION (Street and Number or Rural Route Number, City or Town, State)																			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>2/28/94</b>													
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Alonso Gomez, M.D. 419 S. Union Ave. Harford Co. Md 21078</b>																			
31. DATE FILED (Month, Day, Year) <b>MAR 1 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>															

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEPARTMENT OF COMMERCE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

1914

94 06631

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES JOSEPH GAMBO</b>				2. DATE OF DEATH MONTH DAY YEAR <b>03 01 1994</b>		3. TIME OF DEATH <b>1107 P M</b>	
4. SOCIAL SECURITY NUMBER <b>213 36 4970</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>52</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3-9-41</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Greater Baltimore Medical Cnt</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		8c. COUNTY OF DEATH <b>Baltimore Co</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>na</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>118 Stanmore Road</b>				10f. ZIP CODE <b>21212</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1958-62</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12+</b> College (13-16) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mech/Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Consultant</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Americo Gambo</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Barbara Cataldi</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs Rosemarie Gambo</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>118 Stanmore Road, Balto, MD 21212</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade</i>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board 655W. Baltimore St, Balto, MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>VENTRICULAR TACHYCARDIA</b> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>Coronary Arteriosclerosis</b> DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Heath M.D.</i>		29c. LICENSE NUMBER <b>D15476</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/2/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RONALD F. SHER M.D.</b>							
31. DATE OF DEATH (Month, Day, Year) <b>MAR 01 1994</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

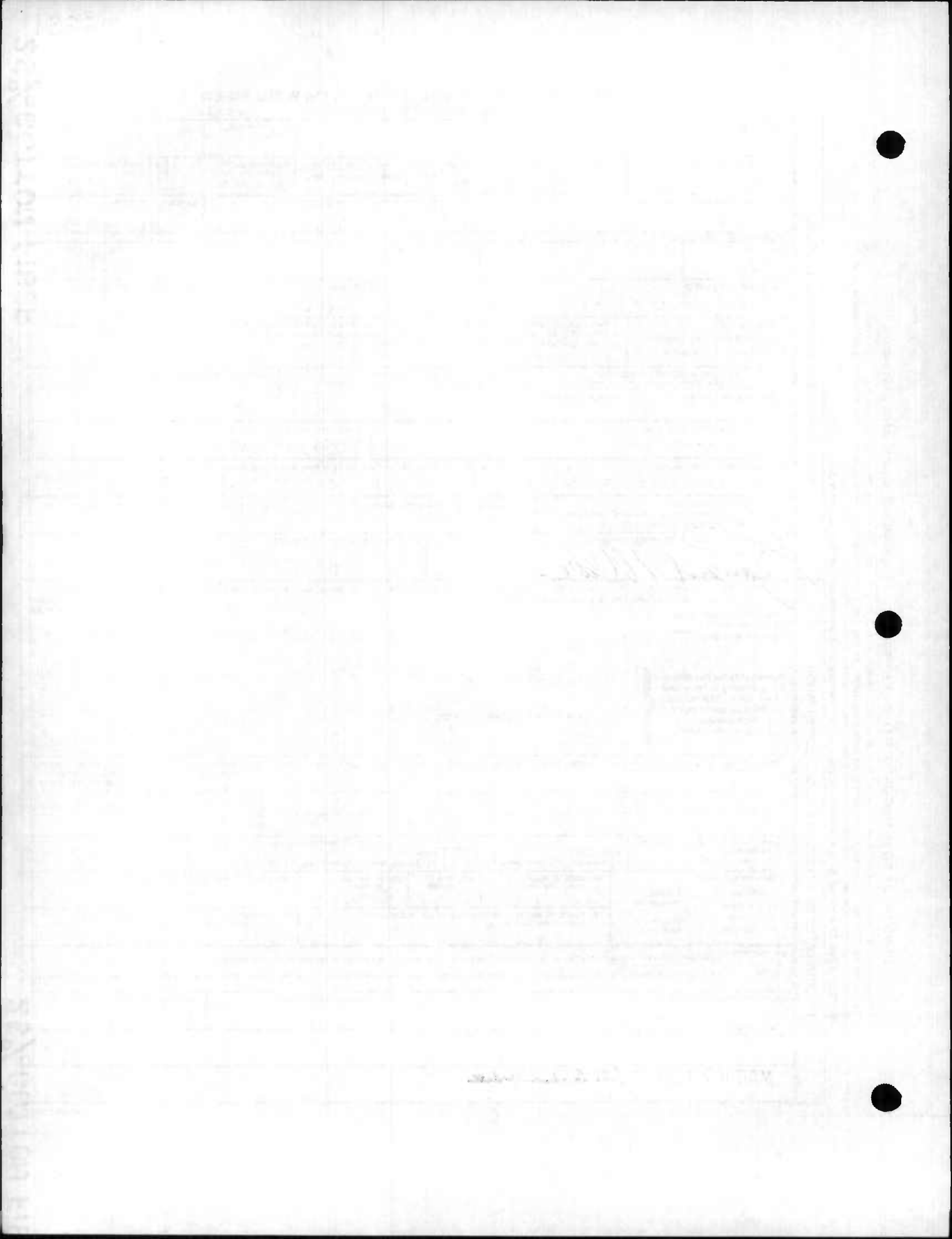
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06632

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Gladys Gladney</i>				2. DATE OF DEATH MONTH <i>3</i> DAY <i>3</i> YEAR <i>94</i>		3. TIME OF DEATH <i>1300 M</i>	
4. SOCIAL SECURITY NUMBER <i>220-14-2494</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>77</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>10-5-16</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>ST. AGNES HOSPITAL</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i>		9c. COUNTY OF DEATH <i>N/A</i>	
10a. STATE <i>MD</i>				10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>4001 COLBOURNE ROAD</i>			
10f. ZIP CODE <i>21229</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11TH</i> College (1-4 or 5+) <i>N/A</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>N/A</i>		16b. KIND OF BUSINESS/INDUSTRY <i>N/A</i>			
17. FATHER'S NAME (First, Middle, Last) <i>JOE EDGER</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>EUNICE RATTERIEE</i>			
19a. INFORMANT'S NAME (Type/Print) <i>JOE LOUIS GLADNEY</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4001 COLBOURNE RD/BALTIMORE, MD 21229</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>WHITE OAK CEMETERY</i>		DATE		20c. LOCATION — City or Town, State <i>WHITE OAK, S.C.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Debbie K. Jones</i>				22. NAME AND ADDRESS OF FACILITY <i>WM.C.MARCH F.H./1101 E. NORTH AVENUE</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Seizure</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>infected wounds both earlier</i> b. <i>Diabetes</i> c. <i>severe, latent cardiovascular pathology</i> d. <i>1 week</i> <i>1 month</i> <i>years</i> <i>years</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>HTN</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <i>NA</i>		28b. TIME OF INJURY <i>NA</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <i>NA</i>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>NA</i>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>NA</i>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeffrey S. Willey</i>				29c. LICENSE NUMBER <i>Resident</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/3/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Jeffrey S. Willey 900 caton Av Baltimore MD</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 07 1994</i>				32. REGISTRAR'S SIGNATURE <i>Gina Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RAYMOND ANTHONY GEBHARDT, SR.</b>			2. DATE OF DEATH MONTH <b>Mar</b> DAY <b>6</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>3:35 pm</b>
4. SOCIAL SECURITY NUMBER <b>212-05-5769-A</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>80</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 4, 1913</b>	8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Saint Joseph Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT					
10a. STATE <b>Maryland</b>	10b. COUNTY <b>Baltimore</b>	10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>21 Juliet Lane, Unit 304</b>		10f. ZIP CODE <b>21236</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Electrical-Gen'l Supr.</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Baltimore Gas &amp; Electric</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Christopher John Gebhardt</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen Marble</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Anne M. Gebhardt (wife)</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21 Juliet Lane, Unit 304, Baltimore, MD 21236</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem'l Maus. 3/9</b>		20c. LOCATION — City or Town, State <b>Timonium, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. METASTATIC RECTAL CARCINOMA</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death <b>1 YR</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Beatriz P. Dizon M.D.</b>		29c. LICENSE NUMBER <b>D16492</b>	29d. DATE SIGNED (Month, Day, Year) <b>Mar 6, 1994</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BEATRIZ P. DIZON, M.D., ST. JOSEPH HOSPITAL, 7620 YORK RD., TOWSON, MD 21204</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b> 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ST. JOSEPH HOSPITAL

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ST. JOSEPH HOSPITAL, 1000 YORK RD, TOWSON, MD 21204



94-1047-510

DWG

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Item 17 3-7-94 Film G709 W.H. Per F/H

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LEROY F. GARVIN</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>03</b> YEAR <b>94</b>		3. TIME OF DEATH <b>1:14A</b> M	
4. SOCIAL SECURITY NUMBER <b>216-18-4391</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-26-1924</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>UNIVERSITY MARYLAND S.T.U.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>Md</b>	
10a. STATE <b>Md</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>318 Gwynn Avenue</b>			
10f. ZIP CODE <b>21229</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Bethlehem Steel</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Peter Garvin</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bessie Jackson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy E. Garvin</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>318 Gwynn Avenue Baltimore, Md 21229</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Vet 3894</b>		20c. LOCATION — City or Town, State <b>Owings Mills, Md</b>		20d. DATE <b>March F/H West</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jerome A. Thompson Jr</b>				22. NAME AND ADDRESS OF FACILITY <b>4300 Wabash Avenue</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Multiple Injuries</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>03/02/94</b>		28b. TIME OF INJURY <b>11:10P</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>ROADWAY</b>		28e. DESCRIBE HOW INJURY OCCURRED <b>DRIVER IN AUTO/AUTO IMPACT</b>			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>70 NEAR RIE 75</b>					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Samuel J. Chute</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 03/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>		32. REGISTRAR'S SIGNATURE <b>John K. ...</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ASP

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-709 3/17/94 t.t.

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MICHELE D. GERMAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 02 1994</b>		3. TIME OF DEATH P M <b>10:02 P M</b>	
4. SOCIAL SECURITY NUMBER <b>215-66-0519</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>36</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-6-1957</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HARBOR HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1108 SHELLBANKS ROAD</b>				10f. ZIP CODE <b>21225</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>HARRY RICE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GERALDINE POWELL</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GERALDINE SELBY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2824 MILES AVENUE, BALTIMORE, MARYLAND 21211</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		DATE		20c. LOCATION — City or Town, State <b>BALTIMORE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CARDIAC ARRHYTHMIA ASSOCIATED WITH ACUTE COCAINE INTOXICATION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>FOUND: 3-2-94</b>		28b. TIME OF INJURY <b>9:20 P M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED <b>UNKNOWN</b>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1108 SHELLBANKS ROAD BALTIMORE, MARYLAND</b>	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>O.C.M.E.</b>	
29d. DATE SIGNED (Month, Day, Year) <b>MARCH 03, 1994</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>			
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LEONARDO D. GILLUS</b>				2. DATE OF DEATH MONTH <b>FEB</b> DAY <b>25</b> YEAR <b>94</b>		3. TIME OF DEATH <b>11:35 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>223-70-7309</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>35</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-15-59</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>UNIVERSITY S.T.U.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Maryland</b>			
10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>855 Eversham Ave</b>			
10f. ZIP CODE <b>21212</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Trucking</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>LASSIS Gillus</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Verly Muse</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Patricia Gillus</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>855 Eversham Ave. Baltimore Md 21212</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <b>King Memorial Park Feb 23</b>		20c. LOCATION — City or Town, State <b>Baltimore Co. Md</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph L. Russ</b>	
22. NAME AND ADDRESS OF FACILITY <b>Joseph L. Russ Funeral Home</b>		22. NAME AND ADDRESS OF FACILITY <b>2332 W. North Ave. Baltimore</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GUNSHOT WOUND OF HEAD</b> b. <b>QUE TO (OR AS A CONSEQUENCE OF):</b> c. <b>QUE TO (OR AS A CONSEQUENCE OF):</b> d. <b>QUE TO (OR AS A CONSEQUENCE OF):</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>FEB 25, 1994</b>	
28b. TIME OF INJURY <b>2:04 P.M.</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT SHOT</b>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1600 LILJONES COURT</b>	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Marvin Meyhall</b>		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB 26, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Leonardo A. Koron 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>		32. REGISTRAR'S SIGNATURE <b>John Andrew Rudek</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EDWARD A. (aka-Graboskie) GRABOWSKI</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>6</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>4:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>188-14-3291</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 18, 1923</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9. COUNTY OF DEATH <b>—</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>			
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>—</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>419 S. Collington Avenue</b>				10f. ZIP CODE <b>21231</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>0</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Pipefitter</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Steel Mfg.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Chester Grabowski</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Binkowski</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Denise Hartsell</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>205 9th Ave. S.E. Glen Burnie, Md. 21061</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holy Rosary Cemetery 3/9</b>		20c. LOCATION — City or Town, State <b>Balto. Co., Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Raymond A. Weber (Pres.)</b> <b>George A. Weber &amp; Sons Inc.</b>				22. NAME AND ADDRESS OF FACILITY <b>George A. Weber &amp; Sons Inc.</b> <b>705 S. Ann St. Balto. Md. 21231</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>stroke</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
b. <b>myocardial infarction</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. _____							
DUE TO (OR AS A CONSEQUENCE OF):							
d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Kenneth MD</b>				29c. LICENSE NUMBER <b>L9787</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/6/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Frederick Wenzel, MD - Tower 110 Johns Hopkins</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GIBBONS, WILLIAM</b> (William M. Gibbons)				2. DATE OF DEATH MONTH <b>2</b> DAY <b>27</b> YEAR <b>94</b>		3. TIME OF DEATH <b>2:15 P.</b>		
4. SOCIAL SECURITY NUMBER <b>175-01-0657</b>		5. SEX <b>1</b> M <b>2</b> F		6. AGE (In yrs., last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-7-1903</b>		
8a. FACILITY NAME (If not institution, give street and number) <b>LORIE NURSING AND REHAB.</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>6334 CEDAR LANE</b>		8c. COUNTY OF DEATH <b>HOWARD.</b>		
RESIDENCE OF DECEDENT								
10a. STATE <b>Md.</b>		10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Highland</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>7510 Greenwood Drive</b>				10f. ZIP CODE <b>20777</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>11</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Technician</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Public Utility</b>				
17. FATHER'S NAME (First, Middle, Last) <b>John C. Gibbons</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Reich</b>				
19a. INFORMANT'S NAME (Type/Print) <b>Betty Porreca</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7510 Greenwood Drive Highland, Maryland 20777</b>				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hill Grove Cemetery 3/2</b>		20c. LOCATION — City or Town, State <b>Connellsville, Pennsylvania</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Michael P. Marzullo</b>				22. NAME AND ADDRESS OF FACILITY <b>Marzullo Funeral Service 3981 Carrollton Road Upperco, Maryland 21155</b>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>infected decubiti ulcers</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>Alimentia</b> <b>Chronic obstructive pulmonary disease</b>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alimentia</b> <b>Chronic obstructive pulmonary disease</b>							Approximate interval between Onset and Death <b>days</b> <b>weeks</b> <b>months</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>B. J. Pruccia, M.D.</b>		29c. LICENSE NUMBER <b>D09283</b>		29d. DATE SIGNED (Month, Day, Year) <b>02/27/94</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>9501 Old Annapolis Rd; Sillicott City, Md. 21043</b>								
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>		32. REGISTRAR'S SIGNATURE <b>John M. ...</b>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.



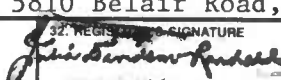
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Edgar E. Hartner</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 3, 1994</b>		3. TIME OF DEATH <b>12:00 A M</b>	
4. SOCIAL SECURITY NUMBER <b>705-10-6435</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 24, 1907</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>3415 Mayfield Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Maryland</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>---</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3415 Mayfield Avenue</b>				10f. ZIP CODE <b>21213</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Machinist</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Railroad Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Hartner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ann Franz</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gary Hartner (Son)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>602 College Avenue, Lutherville, Md. 21093</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Most Holy Redeemer Cem. 3/7</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Baltimore, Md. 21213</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>ALZHEIMER'S DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>920673</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. George Lowe, 5810 Belair Road, Baltimore, Md. 21206</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Elease Harvin</b>				2. DATE OF DEATH MONTH <b>Feb</b> DAY <b>23</b> YEAR <b>94</b>		3. TIME OF DEATH <b>10:53 P M</b>	
4. SOCIAL SECURITY NUMBER <b>218-09-0118</b>		5. SEX <b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>79</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	7. DATE OF BIRTH (Month, Day, Year) <b>8/5/14</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Union Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTO</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>740 POPLAR GROVE ST.</b>				10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+) <b>UNKNOWN</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNKNOWN</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>CARTER DAVIS</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HONEY DAVIS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>WILLIE M. CHEEKS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1338 PENTRIDGE RD BALTO, MD 21239</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MD NATIONAL MEMORIAL PK 22894</b>		DATE		20c. LOCATION — City or Town, State <b>LAUREL, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sala March</i>				22. NAME AND ADDRESS OF FACILITY <b>MARCH F/H-WEST 4300 WABASH AVE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Arrest</b> Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>Severe CHF</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Decubitus ulcer</b> <b>high prothrombin time</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>NA</b>		28b. TIME OF INJURY <b>NA</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>NA</b>				28d. DESCRIBE HOW INJURY OCCURRED <b>NA</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sanyay Shah MD.</i>		29c. LICENSE NUMBER <b>AT2438946E14</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/23/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Sanyay Shah UMH Baltimore MD 21218</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06641

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Helen D. Hunter</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 3 1994</b>		3. TIME OF DEATH <b>10 05 P M</b>	
4. SOCIAL SECURITY NUMBER <b>244-18-1831</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-12-21</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Md</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Balto</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>2928 N. Edgecombe Circle</b>		10f. ZIP CODE <b>21215</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY <b>Rosewood State Hosp</b>		17. FATHER'S NAME (First, Middle, Last) <b>Gideon Alston</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Beulah Gomis</b>				19a. INFORMANT'S NAME (Type/Print) <b>Edna Harris</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1022 Valley St Balto, Md 21202</b>	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Druid Ridge Cem 3/8/94</b>		20c. LOCATION — City or Town, State <b>Balto, Md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Portia Chron</b>				22. NAME AND ADDRESS OF FACILITY <b>Mark F.A. West 4300 Wabash Ave</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CVA</b>				DUE TO (OR AS A CONSEQUENCE OF): <b>antiphospholipid syndrome</b>		Approximate interval Between Onset and Death <b>1 month</b>	
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST				DUE TO (OR AS A CONSEQUENCE OF):		1 month	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Brian J. Keable MD</b>		29c. LICENSE NUMBER	
29d. DATE SIGNED (Month, Day, Year) <b>3/7/94</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Sinai Hospital of Baltimore</b>		31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>	
31. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CLARA HEARD</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 22, 1994</b>		3. TIME OF DEATH <b>2:12 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214-20-6899-m</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-11-1918</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>Maryland</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1428 N. Eden St</b>				10f. ZIP CODE <b>21213</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Torini</b>				18. MOTHER'S NAME (First, Middle, Maiden Name) <b>Rebecca Saunders</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Sylvia Martin</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1428 N. Eden St. Balto. Md. 21213</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Greenmount Cem 3/2</b>		20c. LOCATION — City or Town, State <b>Balto. Md.</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph L. Russ</b>				22. NAME AND ADDRESS OF FACILITY <b>Joseph L. Russ Funeral Home 227 W. North Ave. Balto. Md 21206</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>sepsis</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>UTI - urinary tract infection</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature] MD</b>				29c. LICENSE NUMBER <b>L9787</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/22/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Fred Wenzel, M.D. Tower 110 Johns Hopkins</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STANDARD HIGH

THE UNIVERSITY OF CHICAGO

IN THE DEPARTMENT OF

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CARRIE M HALL</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>05</b> YEAR <b>94</b>		3. TIME OF DEATH <b>01:45 AM</b>	
4. SOCIAL SECURITY NUMBER <b>217-09-8976</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08 25 07</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>	
9c. COUNTY OF DEATH <b>A.A. COUNTY</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>WORCESTER</b>	
10c. CITY, TOWN OR LOCATION <b>BERLIN</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>11003 GRAYS CORNER ROAD #118</b>	
10f. ZIP CODE <b>21811</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SECRETERY</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. GOVERNMENT</b>	
17. FATHER'S NAME (First, Middle, Last) <b>MICHAEL J. RAFFERTY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>KATHERINE WAGNER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MICHAEL J. HALL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>144 LOUISE TERRACE—GLEN BURNIE, MD. 21060</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>NEW CATHEDRAL</b>		20c. LOCATION — City or Town, State <b>3/8 BALTIMORE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY <b>RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE RESPIRATORY FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>12 hrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ALZHEIMER'S DISEASE</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>N/A</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. Mursch Attending</i>				29c. LICENSE NUMBER <b>D 21776</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/5/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SURYA P. MUNDRA M.D./1600 CRAIN HIGHWAY SW #208/GLEN BURNIE MARYLAND 21061</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed in the funeral director's office. Page 4 should be filed in the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HONORABLE  
MEMBERS OF THE  
HOUSE OF REPRESENTATIVES  
WASHINGTON, D. C.

Dear Sirs:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the proposed amendment to the Constitution of the United States, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Your obedient servant,  
J. M. [Signature]

Very truly yours,  
J. M. [Signature]

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GLORIA ANDERSON HOOVLER</b>				2. DATE OF DEATH <b>FEBRUARY DAY 28, 1994</b>		3. TIME OF DEATH <b>4:10 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>175-18-8525</b>		5. SEX <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN. 15, 1923</b>	
8. BIRTHPLACE (State or Foreign County) <b>PA.</b>				9. COUNTY OF DEATH			
10a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				10b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		10c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>PA.</b>		10b. COUNTY <b>JEFFERSON</b>		10c. CITY, TOWN OR LOCATION <b>PUNXSUTAWNEY</b>		10d. INSIDE CITY LIMITS? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>	
10e. STREET AND NUMBER <b>RD #6</b>				10f. ZIP CODE <b>15767</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>ELMER ANDERSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ALBERTA BROWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DAVID HOOVLER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 1031 COLLEGE PARK, MD. 20741</b>			
20a. METHOD OF DISPOSITION <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CIRCLE HILL CEM 3-4-94</b>		20c. LOCATION — City or Town, State <b>PUNXSUTAWNEY PA.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Thomas J. Spadock</b>				22. NAME AND ADDRESS OF FACILITY <b>7213 LEE HWY CAPITOL FEDERAL SER. FALLS CHURCH PA.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Multiple Myeloma</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>							Approximate Interval Between Onset and Death <b>~ 1 yr</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>acute renal failure</b>							24a. WAS AN AUTOPSY PERFORMED? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> OTHER: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>					
27. MANNER OF DEATH <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <b>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2 <input type="checkbox"/> MEDICAL EXAMINER:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Shellen Hawkins MD</b>				29c. LICENSE NUMBER <b>L9706</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/28/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Shellen Hawkins Johns Hopkins Hospital BALTIMORE MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>		32. REGISTRAR'S SIGNATURE <b>Jake Davidson-Rodell</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ALBERT J. JUSKUS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 4th 1994</b>		3. TIME OF DEATH <b>7:50 PM</b>	
4. SOCIAL SECURITY NUMBER <b>218-05-0646</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 25, 1920</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4515 WILMSLOW ROAD</b>				10f. ZIP CODE <b>21210</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CHIEF OF FIRE MAINTENANCE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CITY OF BALTO.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOSEPH JUSKUS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>VERONICA SKELPSA</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ANGELA C. JUSKUS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4515 WILMSLOW ROAD BALTIMORE, MD. 21210</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>HOLY REDEEMER CEM. 3/7/94</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Dolan</i> <b>JOHN E. DOLAN</b>				22. NAME AND ADDRESS OF FACILITY <b>LEONARD J. RUCK INC. 5305 HARFORD ROAD BALTIMORE, MD. 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ch. Renal failure / Pul edema vs HTN</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>D.M., HTN., Sacral Decubiti</b> DUE TO (OR AS A CONSEQUENCE OF): <b>D.M., Osteomyelitis, Hypothyroidism</b> DUE TO (OR AS A CONSEQUENCE OF): <b>D.M.</b>						Approximate Interval Between Onset and Death <b>Weeks</b> <b>10 yr.</b> <b>15 yr.</b> <b>20 yr.</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>D.M., HTN, Ch. Renal failure, Pul edema (Pul HTN, Sacral Decubiti)</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Siddiqi</i> <b>M.D.</b>				29c. LICENSE NUMBER <b>802438946</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 4th, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NAHID SIDDIQI, DEPT. MED. UMH. E. UNIV. PKWY, BALTO</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without delay after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Loretta D. Jones</b>				2. DATE OF DEATH MONTH DAY YEAR <b>02 25 94</b>		3. TIME OF DEATH <b>1530 p m</b>	
4. SOCIAL SECURITY NUMBER <b>216-50-0031</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>45</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>04 06 48</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Union Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
10a. STATE <b>MD.</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1711 E. 32nd Street</b>			
10f. ZIP CODE <b>21218</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>1yr</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Admin. Asst.</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Wilbur A. Walker Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mildred Henson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ollie J. Jones</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1711 E. 32nd Street Balto., MD. 21218</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Vet. Cem.</b>		20c. LOCATION — City or Town, State <b>Owingsmills, MD.</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> <b>CFSP #281</b>	
22. NAME AND ADDRESS OF FACILITY <b>1721-27 N. Monroe ST. E.L. Phillips F/H Balto., MD. 21217</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebral Aneurysm Rupture</b> HTN  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>6 hrs</b> <b>20 yrs.</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> <b>MD</b>				29c. LICENSE NUMBER <b>AT2438946F20</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/25/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ramy S. Hanna, MD</b> <b>UMH Balto, MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANDRE JACKSON</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>28</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>4:20 A. M.</b>	
4. SOCIAL SECURITY NUMBER <b>218-78-3741</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>37</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-23-1956</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>UNIVERSITY HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH				10a. STATE <b>MD.</b>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>322 SOUTH FRANKLINTOWN ROAD</b>	
10f. ZIP CODE <b>21223</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>NAPOLEON JACKSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SARAH JACKSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>SARAH JACKSON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>322 S. FRANKLINTOWN ROAD, BALTIMORE, MD. 21223</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARBUTUS CEMETERY</b>		20c. LOCATION — City or Town, State <b>ARBUTUS, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph H. Brown Jr.</i>				22. NAME AND ADDRESS OF FACILITY <b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>Respiratory failure</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>End-stage human immunodeficiency virus infection</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>E. Tao, MD</b>				29c. LICENSE NUMBER <b>D24170</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-1-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>UNIV of MD MEDICAL CTR BALTIMORE</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

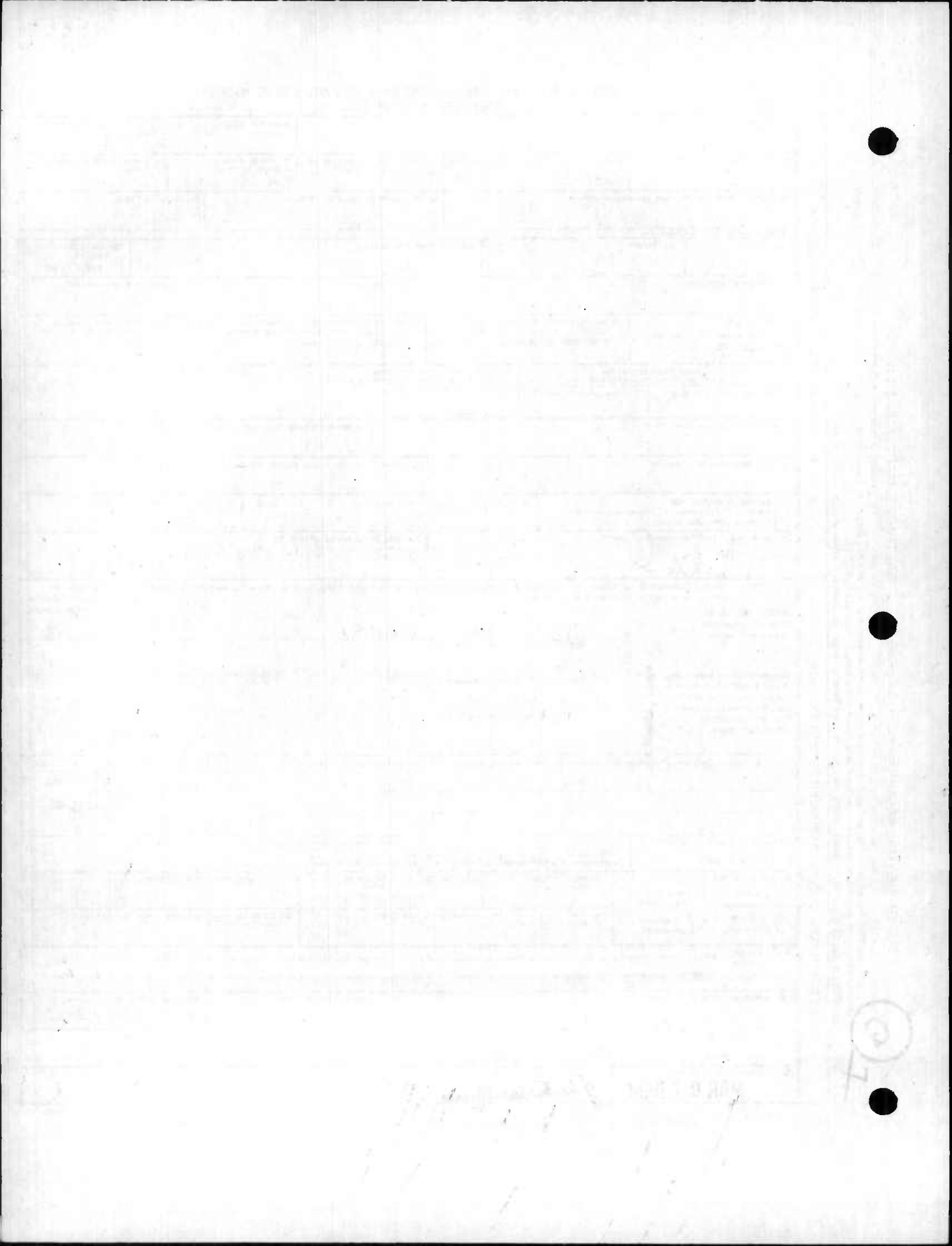
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06648

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Bertha Johnson</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>02</b> YEAR <b>94</b>		3. TIME OF DEATH <b>0728</b> M	
4. SOCIAL SECURITY NUMBER <b>231-05-9038</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8-12-25</b>	
8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>U. of Md. Cancer Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH				10a. STATE <b>MARYLAND</b>			
10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>260 Robert Street</b>				10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify		14. RACE — American Indian, Black, White, etc. Specify <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chef</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Restaurant</b>	
17. FATHER'S NAME (First, Middle, Last) <b>ERNEST</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>IDA FIELDS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>BEATRICE JOHNSON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>260 ROBERT ST. A2 BALTIMORE, MD 21217</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK 3/7</b>		20c. LOCATION — City or Town, State <b>RANDALLSTOWN, MD</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Leroy O. Dyett</b>	
22. NAME AND ADDRESS OF FACILITY <b>LERROY O. DYETT &amp; SON FUNERAL HOME</b>		22. ADDRESS OF FACILITY <b>4600 LIBERTY HEIGHTS AVENUE 21207</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>acidosis</b> a. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>sepsis</b> c. <b>Leukemia</b> d.  Approximate Interval Between Onset and Death <b>1 day</b> <b>4 weeks</b> <b>5 months</b>		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Michael Brave MD</b>	
29c. LICENSE NUMBER <b>D36131</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/2/94</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>University of MD Cancer Center</b>		31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>	
32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06649

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Claire A. Johnson</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 21, 1994</b>		3. TIME OF DEATH <b>3:45 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>472-22-6101</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>65</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 19, 1928</b>		8. BIRTHPLACE (State or Foreign Country) <b>Minnesota</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>The Keswick Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>-----</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>-----</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>700 W. 40th. St.</b>				10f. ZIP CODE <b>21211</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Korea</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>6</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Administrator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Social Security Admin.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Olaus Johnson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary L. Shaw</b>			
19a. INFORMANT'S NAME (Type/Print) <b>C. Read Carter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3900 N. Charles St. Balto. Md. 21218</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Greenmount Cem. Cremtry 2/24/94 Balto. Md.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert M. Kratz</b>				22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Balto. Md. 21212</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Congestive heart failure</b>					Approximate Interval Between Onset and Death <b>1 year</b>
		b. <b>Ischemic cardiomyopathy</b>					<b>4 years</b>
		c. <b>Hypertension</b>					<b>30 years</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>M. Isabelle MacGregor M.D.</b>				29c. LICENSE NUMBER <b>D13657</b>		29d. DATE SIGNED (Month, Day, Year) <b>February 21, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>M. ISABELLE MacGREGOR M.D., KESWICK, 700 W. 40th ST. BALTIMORE, MD 21211</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECRET

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1. The purpose of this document is to provide information regarding the activities of the [redacted] organization. This information is being provided to you for your information only and is not to be distributed outside of your organization.

2. The [redacted] organization is a [redacted] organization that is active in the [redacted] area. It is a [redacted] organization that is active in the [redacted] area. It is a [redacted] organization that is active in the [redacted] area.

3. The [redacted] organization is a [redacted] organization that is active in the [redacted] area. It is a [redacted] organization that is active in the [redacted] area. It is a [redacted] organization that is active in the [redacted] area.

4. The [redacted] organization is a [redacted] organization that is active in the [redacted] area. It is a [redacted] organization that is active in the [redacted] area. It is a [redacted] organization that is active in the [redacted] area.

5. The [redacted] organization is a [redacted] organization that is active in the [redacted] area. It is a [redacted] organization that is active in the [redacted] area. It is a [redacted] organization that is active in the [redacted] area.

SECRET

6



94-1010-510

blh

Item # 1 fil # G 709 3-7-94 N.A. Per Funeral Home

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <u>Earl</u> <u>Kennedy</u> II				2. DATE OF DEATH MONTH DAY YEAR <u>Feb</u> <u>28</u> <u>1994</u>		3. TIME OF DEATH <u>1755</u> M	
4. SOCIAL SECURITY NUMBER <u>128-58-2282</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>19</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>10-14-74</u>	
8. BIRTHPLACE (State or Foreign Country) <u>NEW YORK</u>				9a. FACILITY NAME (If not institution, give street and number) <u>2273 W. Baltimore Street</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore, Md</u>	
9c. COUNTY OF DEATH <u>n/a</u>				10a. STATE <u>MARYLAND</u>		10b. COUNTY <u>n/a</u>	
10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>534 ORCHARD STREET</u>	
10f. ZIP CODE <u>21201</u>				10g. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11 TH</u> College (1-4 or 5+) <u>UNEMPLOYED</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>UNEMPLOYED</u>		16b. KIND OF BUSINESS/INDUSTRY <u>n/a</u>	
17. FATHER'S NAME (First, Middle, Last) <u>HERMAN EARL KENNEDY I</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>CHELSEA RICHARDSON</u>			
19a. INFORMANT'S NAME (Type/Print) <u>CHELSEA RICHARDSON-GEORGE</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>514 PAGE STREET, EASTMAN, GEORGIA 31023</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>WESTERN STAR CEMETERY 03-08 CATONSVILLE, MD</u>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Debbie K. Jones</u>				22. NAME AND ADDRESS OF FACILITY <u>WM. C. MARCH FH.- 1101 E. NORTH AVE</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Contact Gunshot Wound of Head</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>at scene</u>			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <u>Feb 28 1994</u>		28b. TIME OF INJURY <u>1750</u> M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <u>Self Inflicted Wound</u>				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u>in building</u>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u>2273 W. Baltimore Street</u>							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Dennis J. Chute MD</u>				29c. LICENSE NUMBER <u>O C M E</u>		29d. DATE SIGNED (Month, Day, Year) <u>Mar 01 1994</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Dennis J. Chute, MD, 111 Penn Street, Baltimore, Maryland 21201</u>							
31. DATE FILED (Month, Day, Year) <u>MAR 07 1994</u>				32. REGISTRAR'S SIGNATURE <u>John Anderson Russell</u>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06651

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>John Korzeniewski</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>5</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>5:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214-12-1890</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>09/13/1922</b>	
8. FACILITY NAME (If not institution, give street and number) <b>Church Hospital</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		10. COUNTY OF DEATH <b>N/A</b>	
11. RESIDENCE OF DECEDENT				12. STATE <b>MD</b>		13. COUNTY <b>N/A</b>	
14. STREET AND NUMBER <b>2418 E. Baltimore Street</b>				15. ZIP CODE <b>21224</b>		16. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
17. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		18. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		20. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b></b>				22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Tavern owner</b>		23. KIND OF BUSINESS/INDUSTRY <b>Tavern</b>	
24. FATHER'S NAME (First, Middle, Last) <b>Michael Korzeniewski</b>				25. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jennie Skuzynska</b>			
26. INFORMANT'S NAME (Type/Print) <b>Wanda Korzeniewski</b>				27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2418 E. Baltimore St. Baltimore, Maryland 21224</b>			
28. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holy Rosary Cemetery</b>		30. DATE <b>3/9</b>		31. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
32. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David J. Weber</i>				33. NAME AND ADDRESS OF FACILITY <b>David J. Weber F.H. 401 S. Chester St. Baltimore, Md. 21231</b>			
34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MULTIPLE MYELOMA</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
35. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>BONE METASTASIS</b>							
36. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		37. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
38. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		39. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
40. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		41. DATE OF INJURY (Month, Day, Year)		42. TIME OF INJURY <b>M</b>		43. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
44. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				45. DESCRIBE NOW INJURY OCCURRED			
46. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
47. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
48. SIGNATURE AND TITLE OF CERTIFIER <i>A. K. Nazemi M.D.</i>				49. LICENSE NUMBER <b>017322</b>		50. DATE SIGNED (Month, Day, Year) <b>3/5/94</b>	
51. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
52. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				53. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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U.S. AIR FORCE

RECEIVED

NOV 11 1964

U.S. AIR FORCE



94 06652

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY VIRGINIA KALB				2. DATE OF DEATH MONTH DAY YEAR 03-04-1994		3. TIME OF DEATH 1:15p M	
4. SOCIAL SECURITY NUMBER 217-34-7153		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) 04-02-1900	
9a. FACILITY NAME (If not institution, give street and number) Bon Secours Extended Care				9b. CITY, TOWN OR LOCATION OF DEATH Ellicott City		9c. COUNTY OF DEATH Howard County	
10a. STATE Maryland				10b. COUNTY Howard County		10c. CITY, TOWN OR LOCATION Calrksville	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 5409 Trotter Road				10f. ZIP CODE 21029		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker		16b. KIND OF BUSINESS/INDUSTRY own home			
17. FATHER'S NAME (First, Middle, Last) William Johnson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Dorsey			
19a. INFORMANT'S NAME (Type/Print) Ms. Ella Grimes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5409 Trotter Road, Clarksville, MD 21029			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Linthicum Chpl. Cem 3-8-94		20c. LOCATION — City or Town, State Clarksville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Slack Funeral Home, P.A. Ellicott City, MD 21043			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							3 mo
a. <i>respiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF):							1045
b. <i>congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF):							1047
c. <i>chronic coronary disease</i> DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER 022716		29d. DATE SIGNED (Month, Day, Year) 3/7/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) MAR 07 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



MADE IN U.S.A. 100% COTTON

94 06653

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DANIEL PETER LEFEVRE</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>3</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>3:05 PM</b>	
4. SOCIAL SECURITY NUMBER <b>107 10 9430</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-26-1916</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Perry Point Veteran's Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Perry Point</b>		9c. COUNTY OF DEATH <b>Cecil County</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford County</b>		10c. CITY, TOWN OR LOCATION <b>Aberdeen</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>414 Paradise Road</b>				10f. ZIP CODE <b>21001</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1940-46</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12+</b> College (1-4 or 5+) <b>4</b>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Engineer/Mech</b>		18b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Manfred Worrel Lefevre</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dorothy Cossitt Marsh</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs Sylvia Lefevre</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>414 Paradise Road, Aberdeen, MD 21001</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir</b>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board</b> <b>655W. Baltimore St, Balto, MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>6 Months</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>History of Exposure to Nuclear Radiation</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Elisabeth Sethi</i>				29c. LICENSE NUMBER <b>MD 33177</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ELISABETH SEITHI, M.D., VAMC, PERRY POINT, MD 21902</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <i>Gilia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 06654

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CARROLL LEE</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>2</b> , YEAR <b>1994</b>		3. TIME OF DEATH <b>9:20 p</b> M	
4. SOCIAL SECURITY NUMBER <b>217-07-9096</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-2-13</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>MARYLAND GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>	
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10a. STATE <b>MD</b>		10b. COUNTY <b>N/A</b>		<b>BALTIMORE</b>			
10e. STREET AND NUMBER <b>1926 AISQUITH STREET</b>				10f. ZIP CODE <b>21202</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) <b>12TH</b>		College (1-4 or 5+) <b>N/A</b>		<b>STEEL SIDE</b>		<b>BETHLEHEM STEEL</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JOHN THOMAS LEE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ERRIE GREEN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ROSALYN AUSBY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1835 E. CHASE STREET/BALTIMORE, MD 21213</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTIMORE NATIONAL CEM.</b>		DATE		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVENUE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PROBABLE SEPSIS SECONDARY TO ENDOCARDITIS</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>b. <b>PRECEIPITATED BY ABCESS OF LEFT HIP</b></p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p> </div> </div>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David Ho</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>03 03 94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. DAVID HO M.D. MARYLAND GENERAL HOSPITAL</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 06655

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SHIRLEY LEE</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>2</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>n/a</b>	
4. SOCIAL SECURITY NUMBER <b>213-40-1303</b>		5. SEX <b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>55</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-10-39</b>	
8. BIRTHPLACE (State or Foreign Country) <b>N. CAROLINA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>825 E. 33 RD STREET</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>n/a</b>				10a. STATE <b>MARYLAND</b>			
10b. COUNTY <b>n/a</b>				10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>			
10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>825 E. 33 RD STREET</b>			
10f. ZIP CODE <b>21218</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>n/a</b> College (1-4 or 5+) <b>n/a</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>		16b. KIND OF BUSINESS/INDUSTRY <b>n/a</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JOHN SKINNER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELIZABETH SKINNER BOMAR</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CHAROLETTE LEE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>825 E. 33RD STREET, BALTIMORE, MARYLAND 21218</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTIMORE CEMETERY</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lee V. Holland</i>	
22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH.- 1101 E. NORTH AVENUE</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Hyper Tensive Cardiovascular disease</b> <b>Thrombocytopenia</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Nisha Soprey M.D.</i>				29c. LICENSE NUMBER <b>D24476</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 4, 94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NISHA SOPREY M.D. 2300 Garrison Blvd. Balto Md 21216</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

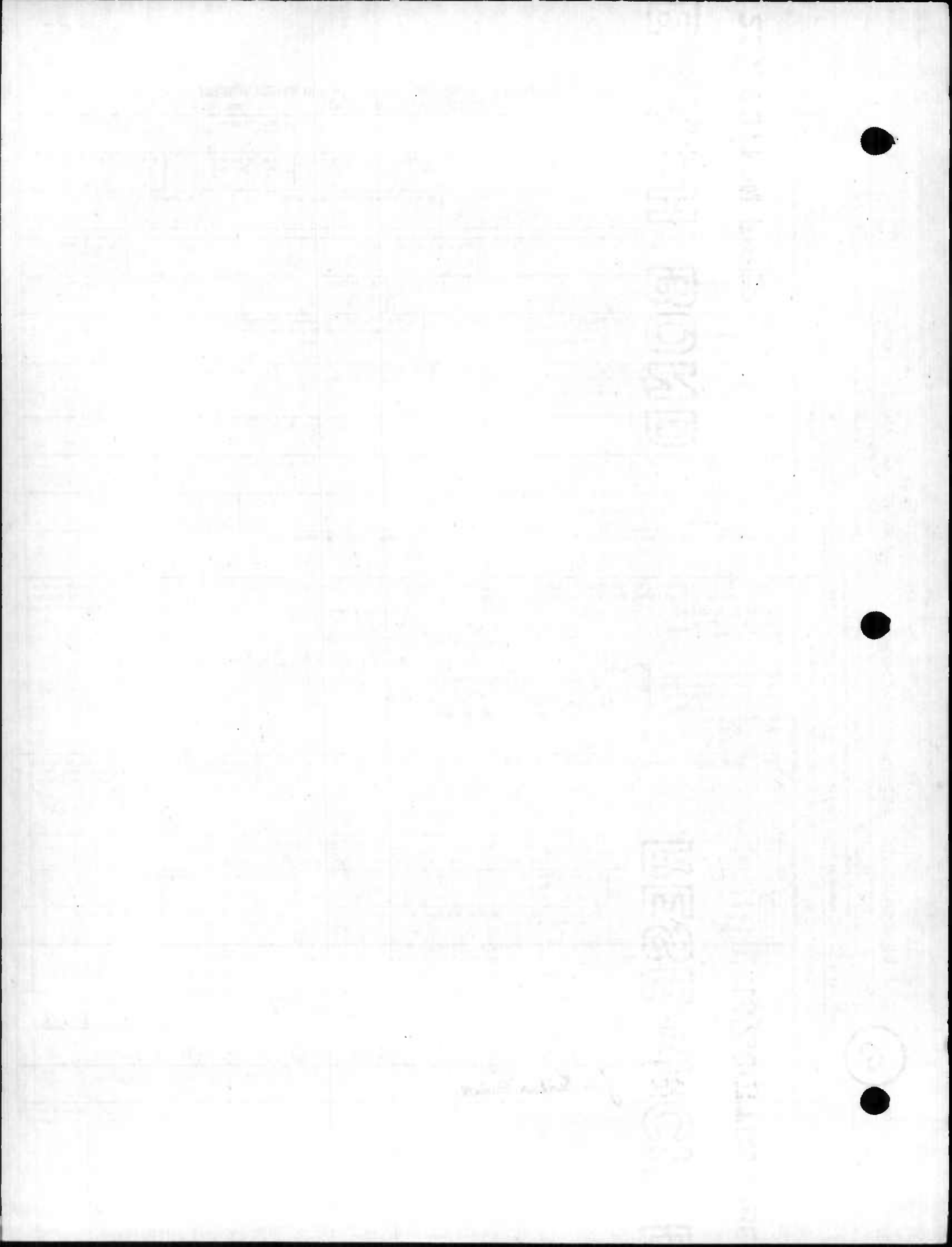
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



THE BUREAU OF

THE BUREAU OF

3

94 06656

Item# 1 Per F.H. Film# G-709 03/11/94

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

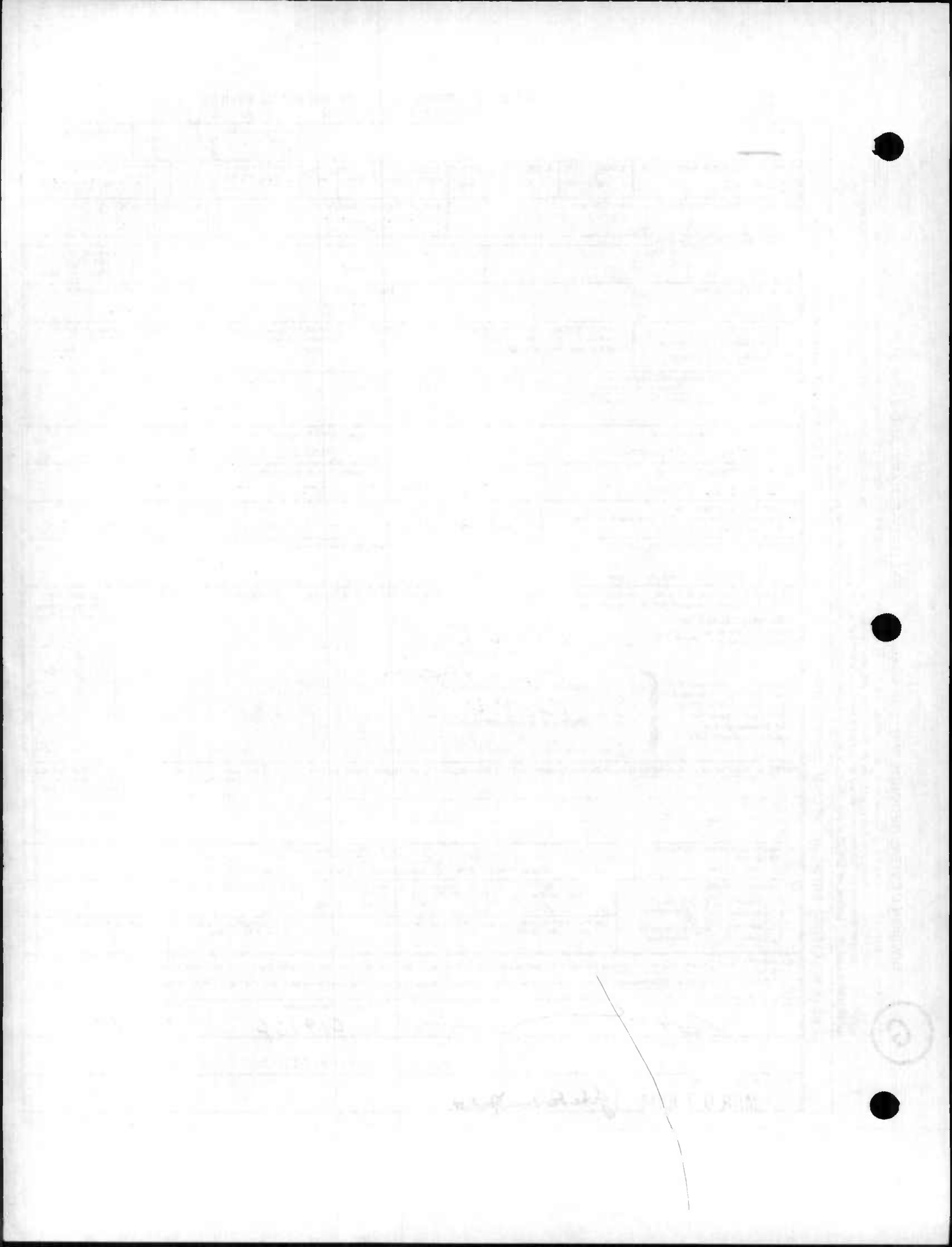
1. DECEDENT'S NAME (First, Middle, Last) <b>Helen L Long</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 4 94</b>		3. TIME OF DEATH M <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>214-74-1458</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>96</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-10-1898</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>10901 Falls Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Lutherville</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Balto.</b>		10c. CITY, TOWN OR LOCATION <b>Lutherville</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>10901 Falls Road</b>			
10f. ZIP CODE <b>21093</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Johnson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Susan Hostedler</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Albert L. Long</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7F. Fellowship Court, Towson, Maryland 21286</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Prospect Hill Cemetery 3-8-94</b>		20c. LOCATION — City or Town, State <b>Towson, Maryland 21204</b>		20d. DATE <b>3-8-94</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Wallace S. Brooks, Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>1050 York Rd. 21204 Rick Towson Funeral Home, Inc.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASCLVD</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Hyper tension</b> c. <b>COPD</b>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>		29c. LICENSE NUMBER <b>019166</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. Alan Baldanza M.D. 10629 York Rd. Cockeysville, Md. 21030</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06657

Item #17, 18 Film # G 709 3-7-94 N.A. Per Funeral Home

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Lillian B. Lewis</i>				2. DATE OF DEATH MONTH <i>3</i> DAY <i>2</i> YEAR <i>94</i>		3. TIME OF DEATH <i>9:10</i> A M	
4. SOCIAL SECURITY NUMBER <i>212-30-0456</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>80</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>6/1/1913</i>	
8. BIRTHPLACE (State or Foreign Country) <i>NEW ORLEANS</i>				9a. FACILITY NAME (If not institution, give street and number) <i>UNIVERSITY HOSPITAL</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i>	
9c. COUNTY OF DEATH <i>BALTIMORE</i>				10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>BALTIMORE</i>	
10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>833 W. PRATT STREET APT. 605</i>	
10f. ZIP CODE <i>21201</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11th</i> College (1-4 or 5+) <i>Housewife</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i>		16b. KIND OF BUSINESS/INDUSTRY <i>N/A</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Unknown Henry Clark</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Unknown Luella</i>			
19a. INFORMANT'S NAME (Type/Print) <i>CHARLES LEWIS</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>833 W. PRATT ST. APT. 605 BALTO., MD 21201</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>MEADOWRIDGE MEM. PARK 3/7</i>		20c. LOCATION — City or Town, State <i>BALTIMORE, MARYLAND</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY <i>LEROY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Interoabdominal Sepsis</i> a. DUE TO (OR AS A CONSEQUENCE OF): <i>Intraabdominal catastrophe</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Severe cardiac disease</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles Claggett, M.D.</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>3/2/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Charles Claggett, M.D. Univ of Md Hosp Center</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 07 1994</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Alice F. Lunn</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>06</b> YEAR <b>94</b>		3. TIME OF DEATH <b>7:40a</b>	
4. SOCIAL SECURITY NUMBER <b>219 105702</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6-22-06</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Liberty Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				RESIDENCE OF DECEDENT			
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2803 PRESSMAN ST</b>				10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOME MAKER</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>SAMUEL COLLINS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARTHA COLLINS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>RUTH SAUNDERS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2816 PRESSMAN ST BALTO MD 21216</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ABRAHAM MEM PARK</b>		20c. LOCATION — City or Town, State <b>BALTO MD</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph L. Rugg</b>				22. NAME AND ADDRESS OF FACILITY <b>JOSEPH L. RUGG FUNERAL HOME</b> <b>2222 W. NORTH AVE 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> a. DUE TO (OR AS A CONSEQUENCE OF): <b>Cerebrovascular Accident</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>Seizure disorder</b> c. DUE TO (OR AS A CONSEQUENCE OF): <b>Urinary tract Infection</b> d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Kervan Elderm</b> House officer				29c. LICENSE NUMBER <b>038993</b>		29d. DATE SIGNED (Month, Day, Year) <b>03/06/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 30, Type, Print) <b>Kervan Elderm 22. S Greene St. Balt. MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <b>John Senior</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

A

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BEULAH E. LEMBACH</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>1</b> YEAR <b>94</b>		3. TIME OF DEATH <b>8:05AM</b>	
4. SOCIAL SECURITY NUMBER <b>214-01-5561</b>		5. SEX <b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02-19-1918</b>	
8. BIRTHPLACE (State or Foreign County) <b>BALTIMORE</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Lorien Nursing &amp; Rehab</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>	
9c. COUNTY OF DEATH <b>HOWARD</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>HOWARD</b>	
10c. CITY, TOWN OR LOCATION <b>Columbia</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>6334 CEDAR LANE</b>	
10f. ZIP CODE <b>21044</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>own home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Frank Colson Ripley</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sara Joyce</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ms. Gayle Kallas</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13316 Folly Quarter Rd., Ellicott City, MD 21042</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maryland Veterans Cem. 3-4-94 Crownsville, MD</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> <b>M00535</b>				22. NAME AND ADDRESS OF FACILITY <b>Slack Funeral Home, P.A. Ellicott City, Maryland 21043</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrhythmia</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { a. <b>Coronary artery disease</b> b. <b>Smoking Cigarettes</b> c. <b></b> d. <b></b>						Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's dementia</b> <b>Breast Carcinoma</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>N/A</b>	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
29b. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29c. DATE SIGNED (Month, Day, Year) <b>3/1/94</b>			
29d. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29e. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>			
29f. LICENSE NUMBER <b>D31575</b>				29g. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>KOLODRUBETZ 9501 Old Annapolis Rd Ellicott City MD</b>			
30. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				31. REGISTRAR'S SIGNATURE <i>[Signature]</i> <b>21042</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[Faint handwritten notes and bleed-through from the reverse side of the page are visible.]*

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANITA LANZA</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>2</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>3:00 a m</b>	
4. SOCIAL SECURITY NUMBER <b>212-05-6219</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 27, 1907</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>109 Thicket Rd.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>109 Thicket Rd.</b>				10f. ZIP CODE <b>21212</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>X</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>X</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Utility Executive</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Baltimore Gas &amp; Electric</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Lanza</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Teresa Defontes</b>			
19a. INFORMANT'S NAME (Type/Print) <b>James P. Cullen</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>109 Thicket Rd. Baltimore, Md. 21212</b>			
20a. MANNER OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Gdns. 3/5</b>		20c. LOCATION — City or Town, State <b>Timonium, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert M. Kratz M00344</b>				22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Wiedefeld Home 6500 York Rd. 21212</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>lung cancer</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): <b>w/o myocardial infarct</b> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. Anthony Serafis</b>				29c. LICENSE NUMBER <b>037362</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Anthony Serafis 1205 York Rd. Timonium, Md.</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06661

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GILBERT McComas LITSINGER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 3 1994</b>		3. TIME OF DEATH <b>1:20 A M</b>	
4. SOCIAL SECURITY NUMBER <b>217-05-2730</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH MONTH DAY YEAR <b>March 5, 1906</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3408 Taney Road</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clergyman</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Church</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William J. Litsinger</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rosa Lowe</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gladys Litsinger</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3408 Taney Road Baltimore, Maryland 21215</b>			
20. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery 3/7</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dennis Stephen Xenakis</i> <b>Dennis Stephen Xenakis</b> , MD0640				22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Wiedefeld Home</b> <b>6500 York Road Baltimore, Maryland 21212</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>UPPER GASTROINTESTINAL BLEEDING</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>EROSIVE GASTRITIS</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>PAUL W. RASSAM, MD</b>				29c. LICENSE NUMBER <b>AT 2438946 F10</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 3, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PAUL RASSAM - 3223 SAINT PAUL ST - BALT - MD 21218</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 06662

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN C. VAN DER MOERE</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>04</b> YEAR <b>94</b>		3. TIME OF DEATH <b>2:18 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>219 222 146</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>68</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>09-25-25</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4507 Simms Ave</b>				10f. ZIP CODE <b>21206</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (14 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sec'y</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Armco Steel</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Stanley E. Reisler</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen Johnson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Arnold A. Van der Moere</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4507 Simms Ave Baltimore, Maryland 21206</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>		20c. DATE <b>3/7</b>		20d. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane Baltimore, Maryland 21213</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE CARDIOVASCULAR COLLAPSE</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. <b>UNKNOWN — OUT OF HOSPITAL ARREST</b>  c.  d.  Approximate Interval Between Onset and Death <b>4 hrs</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>BREAST CA — TERMINAL</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER , MD				29c. LICENSE NUMBER <b>P07640</b>		29d. DATE SIGNED (Month, Day, Year) <b>03 (MAR) 04 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>LIZA ILAG GOOD SAMARITAN HOSPITAL 5601 LOCKRAVEN BLVD BALTO</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Item # 30 File # G 709 3-7-94 N.A. Per. Funeral Home

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CAMILLA BEATRICE MADISON				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 28, 1994		3. TIME OF DEATH n/a	
4. SOCIAL SECURITY NUMBER 213-14-9685		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-29-1900	
8. BIRTHPLACE (State or Foreign Country) ALABAMA		9a. FACILITY NAME (If not institution, give street and number) 5135 HARFORD ROAD		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1766 E. NORTH AVENUE				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) HIGH SCHOOL College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY n/a			
17. FATHER'S NAME (First, Middle, Last) LEVI HUNTINGTON				18. MOTHER'S NAME (First, Middle, Maiden Surname) LUCY SWAYNE			
19a. INFORMANT'S NAME (Type/Print) GLORIA C. SCOTT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 HALLFIELD COURT, BALTIMORE, MARYLAND 21236			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND NATIONAL MEMORIAL PARK		20c. LOCATION — City or Town, State 3-5 LAUREL, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>See Holland</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.- 1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD. DUE TO (OR AS A CONSEQUENCE OF): b. ASCVD DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Sayed MD</i>		29c. LICENSE NUMBER D 18951		29d. DATE SIGNED (Month, Day, Year) 3-3-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 100 N. Broadway Baltimore, Maryland 21231							
31. DATE-FRIED (Month, Day, Year) MAR 07 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 06664

ITEMS: 10f, 11. PER F.H. FILM G-709 3/7/94 t.t

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GENNETTA McRAE</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>1</b> YEAR <b>94</b>		3. TIME OF DEATH <b>1320</b> M	
4. SOCIAL SECURITY NUMBER <b>247-76-5591</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>49</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3-13-1944</b>	
8. BIRTHPLACE (State or Foreign Country) <b>SOUTH CAROLINA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>UNIVERSITY OF MARYLAND HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>MD.</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>705 W. LAFAYETTE AVE. Apt. 2</b>	
10f. ZIP CODE <b>21217</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>n/a</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 TH</b> College (14 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>		16b. KIND OF BUSINESS/INDUSTRY <b>n/a</b>	
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE JACKSON, JR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELIZABETH ANDERSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>BETTY MC RAE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>705 W. LAFAYETTE AVENUE, BALTIMORE, MD 21217</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK 02-05</b>		20c. LOCATION — City or Town, State <b>RANDALLSTOWN, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dee V. Holland</i>				22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH.- 1101 E. NORTH AVENUE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Human Immunodeficiency virus infection</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>months</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>E Tso MD</b>				29c. LICENSE NUMBER <b>D24170</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-1-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Elizabeth Tso MD UNIV of MARYLAND Hosp</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <i>John Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94-1123-005

L.R.B.

Items 10a, 10c, 10e 3-7-94 Film G709 W.H. Per F/H

94 06665

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BRADLEY ALEXANDER MACPHEE</b>			2. DATE OF DEATH MONTH DAY YEAR <b>MAR 04 1994</b>		3. TIME OF DEATH M <b>5:30P</b>
4. SOCIAL SECURITY NUMBER <b>214-35-0708</b>	5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>26</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>MAR 08 1967</b>	8. BIRTHPLACE (State or Foreign Country) <b>Nova Scotia</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PATAPSCO STATE PARK</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>Sydney Ellicott City</b>		9c. COUNTY OF DEATH <b>Baltimore COUNTY</b>
RESIDENCE OF DECEDENT					
10a. STATE <b>Nova Scotia</b>	10b. COUNTY <b>Howard</b>	10c. CITY, TOWN OR LOCATION <b>Sydney Ellicott City</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>214 East Broadway</b>		10f. ZIP CODE <b>21043</b>		10g. CITIZEN OF WHAT COUNTRY? <b>Canada</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Social Worker</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Frank J. MACPHEE</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Darlene MUISE</b>		
19a. INFORMANT'S NAME (Type/Print) <b>MACPHEE, Karen R.</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8864 -C Town &amp; Country Blvd., E. C., Md. 21043</b>		
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>The Green Mount Cemetery 3/07</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry L. Kaufman</i>			22. NAME AND ADDRESS OF FACILITY <b>Gary L. Kaufman Funeral Homes 5695 Main St., Elkridge, Md. 21227</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>HANGING</b> DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ <b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b>					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>MAR 04 94</b>		28b. TIME OF INJURY <b>5:30P</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT HANGED SELF.</b>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>BALTIMORE COUNTY MD.</b>	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Markio F. Golae, Jr. MD</i>			29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAR 05 1994</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARKIO F. GOLAE, JR. MD 111 Penn Street, Baltimore, Maryland 21201.</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>		32. REGISTRAR'S SIGNATURE <i>John A. Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 06666

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) William K. Maddox				2. DATE OF DEATH MONTH DAY YEAR 02 28 94		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 219-30-0290		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 60 YRS.		7. DATE OF BIRTH (Month, Day, Year) 05 06 33	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. COUNTY OF DEATH			
9a. FACILITY NAME (If not institution, give street and number) 2113 Bolton Street				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
10a. STATE MD.				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 2113 Bolton Street				10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Stock Clerk		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) George E. Maddox				18. MOTHER'S NAME (First, Middle, Maiden Surname) Augusta M. Young			
19a. INFORMANT'S NAME (Type/Print) Joseph E. Maddox				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2113 Bolton Street Balto., MD. 21217			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Cathedral Cemetery		20c. LOCATION — City or Town, State Balto., MD.		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Claretta E. Ector</i> CFSP #281				22. NAME AND ADDRESS OF FACILITY 1721-27 N. Monroe ST. E.L. Phillips F/H Balto., MD. 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Squamous Cell Carcinoma of tongue</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Insulin Dependent Diabetes Mellitus</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael V. Woodbridge MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 3/3/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 225 Greene St Dept of Medicine BALTIMORE MD 21202 MICHAEL V. WOODBRIDGE							
31. DATE FILED (Month, Day, Year) MAR 07 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06667

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>Ira E Miller</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>6</b> YEAR <b>94</b>		3. TIME OF DEATH <b>5:25A</b>					
4. SOCIAL SECURITY NUMBER <b>274-09-4587</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>03-27-1915</b>		8. BIRTHPLACE (State or Foreign Country) <b>Penna.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Francis Scott Key</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH			
RESIDENCE OF DECEDENT											
10a. STATE <b>Md</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Edgemere</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>2420 Eugene Ave</b>				10f. ZIP CODE <b>21219</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>4th</b>				15e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerk</b>		16d. KIND OF BUSINESS/INDUSTRY <b>Railroad</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Milton Miller</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sally Ramor</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Virginia Lee</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2404 Maple Rd Edgemere, Md 21219</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>		DATE <b>3/8</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Colt Connolly</b>				22. NAME AND ADDRESS OF FACILITY <b>Connolly Funeral Home of Dundalk 7110 Sollers Pt Rd 21222</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Coronary artery disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>diabetes mellitus</b> DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>2 weeks</b> <b>10 years</b>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Melanie Hagen MD</b>						29c. LICENSE NUMBER <b>045069</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/6/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Melanie Hagen MD Francis Scott Key Medical Ctr Balto</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>							



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Alma Marie Miller				2. DATE OF DEATH MONTH DAY YEAR March 4 94		3. TIME OF DEATH 8:00 A M	
4. SOCIAL SECURITY NUMBER 213-30-8925		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 10, 1910	
8. BIRTHPLACE (State or Foreign Country) MARYLAND							
9a. FACILITY NAME (If not institution, give street and number) 17030 EVNA ROAD				9b. CITY, TOWN OR LOCATION OF DEATH PARKTON		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION PARKTON		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 17030 EVNA ROAD				10f. ZIP CODE 21120		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OFFICE WORK		15b. KIND OF BUSINESS/INDUSTRY BALTIMORE COUNTY GOVT.			
17. FATHER'S NAME (First, Middle, Last) GEORGE HARRY LINZEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET L. DROLL			
19a. INFORMANT'S NAME (Type/Print) ALMA M. GATLEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17030 EVNA ROAD PARKTON, MD. 21120			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARDENS OF FAITH CEM. 3/8/94		20c. LOCATION — City or Town, State BALTIMORE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Dolan</i> JOHN E. DOLAN				22. NAME AND ADDRESS OF FACILITY 5305 Harford Rd. 21214 Leonard J. Ruck, Inc.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic decubitus ulcers DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate Interval Between Onset and Death years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sally Habib</i> mw		29c. LICENSE NUMBER D 42149		29d. DATE SIGNED (Month, Day, Year) Mar 4 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Sally Habib 120 Sister Piere Drive Towson, Maryland 21204							
31. DATE FILED (Month, Day, Year) MAR 07 1994		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Virginia MESSNER</u>				2. DATE OF DEATH MONTH <u>03</u> DAY <u>1</u> YEAR <u>94</u>		3. TIME OF DEATH <u>6:50 AM</u>	
4. SOCIAL SECURITY NUMBER <u>216-16-5738</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>70</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>2-12-24</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Howard County General Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Columbia</u>		9c. COUNTY OF DEATH <u>Howard</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Howard</u>		10c. CITY, TOWN OR LOCATION <u>Ellicott City</u>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>3022 St. Johns Lane</u>				10f. ZIP CODE <u>21042</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>unknown</u> College (1-4 or 5+) <u>unknown</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Assistant</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Doctors Office</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Norman W. Eckles</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Mildred L. Graig</u>			
19a. INFORMANT'S NAME (Type/Print) <u>John Ellsworth Messner</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3022 St. Johns Lane Ellicott City Md. 21042</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>St. Johns Cemetery 3-4-94</u>		20c. LOCATION — City or Town, State <u>Ellicott City, Md.</u>		20d. DATE <u>3-4-94</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>W. A. Smith</u> M00544				22. NAME AND ADDRESS OF FACILITY <u>Slack Funeral Home, P.A.</u> <u>Ellicott City, Maryland, 21043</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Myocardial infarction</u> a. DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <u>2 J</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Congestive heart failure</u> <u>Renal failure</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <u>Interest</u>			
29c. LICENSE NUMBER <u>D37013</u>				29d. DATE SIGNED (Month, Day, Year) <u>3-1-94</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>B. Conner, MD #2051105 Little Patuxent Pkwy Columbia, MD</u>							
31. DATE FILED (Month, Day, Year) <u>MAR 07 1994</u>				32. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u> 21044			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

2



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARISSA MILES</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 01 94</b>		3. TIME OF DEATH <b>7:58P M</b>			
4. SOCIAL SECURITY NUMBER <b>Infant</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>0</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11/11/93</b>		8. BIRTHPLACE (State or Foreign Country) <b>Balto., md</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>NORTH WEST HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>OWINGS MILLS</b>			9c. COUNTY OF DEATH <b>BALTIMORE</b>		
RESIDENCE OF DECEDENT									
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>OWINGS MILLS</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>#2 SHASTA CIRCLE</b>				10f. ZIP CODE <b>21117</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>N/A</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>GARRETT MILES</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>KAY</b>					
19a. INFORMANT'S NAME (Type/Print) <b>KAY MILES</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>#2 SHASTA CIRCLE OWINGS MILLS, MD 21117</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK</b>		DATE		20c. LOCATION — City or Town, State <b>RANDALLSTOWN, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY <b>LEROY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTYHEIGHTS AVENUE 21207</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sudan Infant Death Syndrome</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 02/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>[Signature]</i> <b>111 Penn Street, Baltimore, Maryland 21201</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH.

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES Thomas NOBLE</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>2</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>10:55 A M</b>	
4. SOCIAL SECURITY NUMBER <b>217-64-5209</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs, last birthday) <b>40</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8 3 53</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD</b>				9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH				10a. STATE <b>MD</b>			
10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>Balt.</b>			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>1623 E. Lanvale Street</b>			
10f. ZIP CODE <b>21216</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Hispanic American</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>(12)</b> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Labor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self Employed</b>			
17. FATHER'S NAME (First, Middle, Last) <b>MARK Noble</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>OpheLia UKN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Selena Noble</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1623 E Lanvale St 21213</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, etc.) <b>Metro Crematory</b>		20c. LOCATION — City or Town, State <b>Catonsville, Md</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jeff Miller</b>	
22. NAME AND ADDRESS OF FACILITY <b>1634 N. Broadway</b>		23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arrhythmia</b> a. DUE TO (OR AS A CONSEQUENCE OF): <b>Cardiomyopathy</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>30 min</b> <b>2-3 yrs</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HIV (+), IVDA, ETOH</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Resident</b>				29c. LICENSE NUMBER <b>JT481</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/2/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>600 N. Wolfe St Doctor: Louis Johns Hopkins Hosp</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>		32. REGISTRAR'S SIGNATURE <b>John Benner-Rudolph</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
BALTIMORE, MARYLAND 21215-0020TO THE HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>Anna Rosella Ott</b>			2. DATE OF DEATH MONTH DAY YEAR <b>March 2 94</b>		3. TIME OF DEATH <b>4:35 P M</b>	
4. SOCIAL SECURITY NUMBER <b>300 24 5296</b>	5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>67 YRS.</b>	7. DATE OF BIRTH MONTH DAY YEAR <b>5-19-1926</b>	8. BIRTHPLACE (State or Foreign Country) <b>Penna</b>		
9a. FACILITY NAME (If not Institution, give street and number) <b>Memorial Hospital</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>		9c. COUNTY OF DEATH <b>Talbot Co</b>	
RESIDENCE OF DECEDENT						
10a. STATE <b>Maryland</b>	10b. COUNTY <b>Caroline</b>	10c. CITY, TOWN OR LOCATION <b>Greensboro</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>11676 Kibler Road</b>			10f. ZIP CODE <b>21639</b>	10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>no</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY				
17. FATHER'S NAME (First, Middle, Last) <b>Walter A. Naugle</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna M. Wirick</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr Sidney Ott</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11676 Kibler Rd, Greensboro, MD 21639</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE	20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir</b>			22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board 655W. Baltimore St, Balto, MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Esophageal carcinoma</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death <b>1 yr.</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive pulmonary disease atherosclerosis</b>					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. SIGNATURE AND TITLE OF CERTIFIER <b>David H. Sweet</b>			29c. LICENSE NUMBER <b>D39887</b>	29d. DATE SIGNED (Month, Day, Year) <b>3/2/94</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAVID H SWEET 509 Idlewild Ave Easton MD 21601</b>						
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>		32. REGISTRAR'S SIGNATURE <b>Davidson Rodolfo</b>				

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>Isaiah Pulley</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 25, 1994</b>		3. TIME OF DEATH <b>7:30 p M</b>		
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb 25 1994</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital at Easton</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>		9c. COUNTY OF DEATH <b>Talbot</b>		
RESIDENCE OF DECEASED								
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Talbot</b>		10c. CITY, TOWN OR LOCATION <b>Easton</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>119 Hammond St.</b>				10f. ZIP CODE <b>21601</b>		10g. CITIZEN OF WHAT COUNTRY?		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY				
Elementary/Secondary (9-12) <b>N/A</b>		College (1-4 or 5+) <b>N/A</b>		<b>N/A</b>		<b>N/A</b>		
17. FATHER'S NAME (First, Middle, Last) <b>Izone Wardell Pulley</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Tana Potter</b>				
19a. INFORMANT'S NAME (Type/Print) <b>Tana Potter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>119 Hammond St. Easton Md. 21601</b>				
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY				
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cordar Rupture arrest</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. Immaturity</b> <b>c. Premature Labor</b> <b>d.</b>							Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Regis Storch M.D.</b>				29c. LICENSE NUMBER <b>D10760</b>		29d. DATE SIGNED (Month, Day, Year) <b>Feb 1994</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Regis Storch M.D. 505 Dutchmans Lane Easton, Md. 21601</b>								
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE 				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

05020

MADE IN U.S.A.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

1. DECEDENT'S NAME (First, Middle, Last) <b>Michael Petryszak</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 3, 1994</b>				3. TIME OF DEATH <b>5:30 A.</b>	
4. SOCIAL SECURITY NUMBER <b>217-22-7748</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 16, 1928</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>8923 Carlisle Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>				10e. STREET AND NUMBER <b>8923 Carlisle Avenue</b>				10f. ZIP CODE <b>21236</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS <b>1 NEVER MARRIED 2 MARRIED 3 WIDOWED 4 DIVORCED</b>				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES <b>1952-60</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b>				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Paymaster</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Crown, Cork &amp; Seal</b>				17. FATHER'S NAME (First, Middle, Last) <b>Max Petryszak</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Vargo</b>				19a. INFORMANT'S NAME (Type/Print) <b>Louise Petryszak (wife)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8923 Carlisle Ave., Baltimore, MD 21236</b>	
20a. METHOD OF DISPOSITION <b>1 BURIAL 2 CREMATION 3 REMOVAL FROM STATE 4 DONATION 5 OTHER (Specify)</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Joseph's Cemetery 3/5</b>				20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death) → Lung Cancer</b> <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>	
24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>	
26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>				27. MANNER OF DEATH <b>1 Natural 2 Pending Investigation 3 Suicide 4 Homicide 5 Could not be determined</b>				28a. DATE OF INJURY (Month, Day, Year) <b>28b. TIME OF INJURY M 1 YES 2 NO</b>	
28c. INJURY AT WORK? <b>1 YES 2 NO</b>				28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>				29b. SIGNATURE AND TITLE OF CERTIFIER 	
29c. LICENSE NUMBER <b>230929</b>				29d. DATE SIGNED (Month, Day, Year) <b>3/3/94</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Paul Celano, 6569 N. Charles St., Suite 205, Towson, MD 21204</b>	
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE 					



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>STAINBROOK Richard PAUL, Sr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Mar 3 1994</b>		3. TIME OF DEATH <b>12:40 AM</b>	
4. SOCIAL SECURITY NUMBER <b>213-34-7510</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>56</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-20-1937</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Saint Joseph Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Forest Hill</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1430 Sharon Acres Road</b>				10f. ZIP CODE <b>21050</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Produce Manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Giant Food</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Paul Wayne Stainbrook</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Wanda B. Dennison</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Patsy E. Stainbrook</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1430 Sharon Acres Rd. Forest Hill, Maryland 21050</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holly Hill Mem. Gdns. 3/5/1994</b>		20c. LOCATION — City or Town, State <b>Middle River, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Chad W. Lish</b>				22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CEREBROVASCULAR ACCIDENT</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER <b>Francis T. Khoo</b> 29c. LICENSE NUMBER <b>D30263</b> 29d. DATE SIGNED (Month, Day, Year) <b>3-3-94</b> 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FRANCIS T. KHOO, M.D. 7520 YORK RD., TOWSON, MD 21204</b> 31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b> 32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Pondell</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



REG. NO.

DHMH-16 Rev 1/89

TO THE PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \_\_\_\_\_ hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director and returned to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**



94 06677

ITEMS: 27, 28a-f, PER MEO FILM G-711 5/2/94 t.t.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Sophia REINHARDT</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 2, 1994</b>		3. TIME OF DEATH <b>9:40 p M</b>	
4. SOCIAL SECURITY NUMBER <b>218-30-6976</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 22, 1909</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Perry Hall</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4403 Forge Road</b>				10f. ZIP CODE <b>21128</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Salesperson</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Jewelry Store</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Ralph Harrington</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nellie Brown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John P. Reinhardt (son)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7901-A Rolling View Ave., Baltimore, MD 21236</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Camp Chapel U.M. Cemetery 3/7</b>		20c. LOCATION — City or Town, State <b>Perry Hall, Maryland</b>		20d. DATE <b>3/7</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Chronic congestive heart failure</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
<b>Possible aspiration pneumonia</b>							
<b>Status post fracture right hip operated</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>FEB. 22, 1994</b>		28b. TIME OF INJURY <b>4 p M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT COLLAPSED</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HOSPITAL</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>FRANKLIN SQUARE HOSPITAL BALTO. MD.</b>			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D17005</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/2/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GOPAL GURUSWAMY MD 10213 Tuscany Rd. Ellicott City, MD 21043</b>							
31. DATE FILLED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lola Beatrice Randolph				2. DATE OF DEATH MONTH <u>2</u> DAY <u>26</u> YEAR <u>94</u>		3. TIME OF DEATH <u>3:55 P M</u>	
4. SOCIAL SECURITY NUMBER 216-34-2390		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 55 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 03 01 38	
8. BIRTHPLACE (State or Foreign Country) Virginia				9. COUNTY OF DEATH Baltimore			
9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore	
10a. STATE MD.				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 4930 Carmine Avenue				10f. ZIP CODE 21207		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cust.		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) John Satterfield				18. MOTHER'S NAME (First, Middle, Maiden Surname) Henrietta Lee			
19a. INFORMANT'S NAME (Type/Print) Robert E. Randolph				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4930 Carmine Avenue Balto., MD. 21207			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem.		DATE		20c. LOCATION — City or Town, State Owingsmills, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Deetta Satter</i>		CFSP#281		22. NAME AND ADDRESS OF FACILITY 1721-27 N. Monroe St. E.L. Phillips F/H Balto., MD. 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>BRAIN METASTASES</u>							<u>4 mos.</u>
DUE TO (OR AS A CONSEQUENCE OF): <u>LUNG CANCER</u>							<u>2 yrs.</u>
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kendall R Faulkner MD</i>				29c. LICENSE NUMBER D06453		29d. DATE SIGNED (Month, Day, Year) 2/27/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kendall R. Faulkner, MD, 2300 Dulany Valley Road, Towson, Maryland 21204							
31. DATE FILED (Month, Day, Year) MAR 07 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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94-0984-510

B.K.S

94 06679

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-711 5/27/94 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KEYAIRRA ROBINSON</b>		2. DATE OF DEATH MONTH <b>FEB.</b> DAY <b>27</b> YEAR <b>94</b>		3. TIME OF DEATH <b>6:35 A M</b>
4. SOCIAL SECURITY NUMBER <b>218-39-1102</b>	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>8 MOS. YRS.</b>	7. DATE OF BIRTH (Month, Day, Year) <b>6-22-1993</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>MARYLAND</b>
RESIDENCE OF DECEDENT				
10a. STATE <b>MD.</b>	10b. COUNTY	10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER <b>3620 BELVEDERE AVENUE</b>		10f. ZIP CODE <b>21207</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA.</b>
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>		16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) <b>TYRONE ROBINSON</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>TAMIKA LUCKEY</b>		
19a. INFORMANT'S NAME (Type/Print) <b>GEORGE LUCKEY</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>324 N. CALHOUN ST., BALTIMORE, MARYLAND 21223</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. ZION (BABYLAND) CEME.</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>e. HEAD INJURIES</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>2-26-94</b>	28b. TIME OF INJURY <b>3:39 P M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED <b>OTHER CHILD JUMPED ON SUBJECT WHILE PLAYING</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>3620 W. BELVEDERE AVE. BALTIMORE, MARYLAND</b>				
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB. 28, 1994</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>				
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>		32. REGISTRAR'S SIGNATURE 		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 8 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94-1045-025

ASP

94 06680

ITEMS: 23 PART I, 27, PER MEO FILM G-710 4/8/94 t.t.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOE R. RODRIGUEZ</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>02</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>4:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>449-06-9194</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>37</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>October 25, 1956</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>HARFORD MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>HAVRE DE GRACE</b>		9c. COUNTY OF DEATH <b>HARFORD</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Aberdeen</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>1940 Bennett</b>			
10f. ZIP CODE <b>21001</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1980-1992</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: <b>Mexican</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>Mexican-American</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Salesman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Retail</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Ernesto Ruben Rodriguez</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Frances Cortez</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary Frances Garcia</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4634 Orchid Lane Corpus Christi, Texas 78416</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rose Hill Memorial Park 3/7</b>		20c. LOCATION — City or Town, State <b>Corpus Christi, Texas</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Michael P. Marzullo</b>				22. NAME AND ADDRESS OF FACILITY <b>Marzullo Funeral Service 3981 Carrollton Road Upperco, Maryland 21155</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CARDIAC ARRHYTHMIA</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Devin J. Chuteau</b>				29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 03, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>		32. REGISTRAR'S SIGNATURE <b>John S. Anderson</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



REG NO

DHMH-1A Rev 1/89


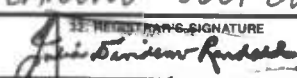
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY E. SCHAUER</b>				2. DATE OF DEATH MONTH <b>MAR</b> DAY <b>06</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>1203A</b>	
4. SOCIAL SECURITY NUMBER <b>217 48 2789</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>43</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 23, 1950</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Good Samaritan Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Maryland</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>9209 Bowline Road</b>				10f. ZIP CODE <b>21236</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Corporate Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Grasmick Lumber Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Thomas C. Rohde</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Hilda Smith</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Stephen C. Schauer (Husband)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9209 Bowline Road, Baltimore, MD 21236</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Joseph's Cemetery</b>		DATE <b>3/9</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SEPTIC SHOCK</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>PNEUMONIA</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. _____							
DUE TO (OR AS A CONSEQUENCE OF):							
d. _____							
Approximate Interval Between Onset and Death <b>8 DAYS</b> <b>8 DAYS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>METASTATIC BREAST CARCINOMA</b> <b>THROMBOCYTOPENIA</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Gabriel H. Nazareno MD</b>				29c. LICENSE NUMBER <b>P07617</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAR 03, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GABRIEL NAZARENO 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06683

Item # 4,8 Film # G 709 3-7-94 N.A. Per Funeral Home

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MADeline M. Seigle</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>2</b> YEAR <b>94</b>		3. TIME OF DEATH <b>3:29 PM</b>	
4. SOCIAL SECURITY NUMBER <b>317 12 0174</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-4-22</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Bm Secours Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>MD.</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>223 S. Mount St.</b>				10f. ZIP CODE <b>21223</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>William Springfield</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maggie Greenfield</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Stanley L. Gover</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5797 Augustine Ave., Elkridge, Md. 21227</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Crownsville Veterans Cem. 3/07</b>		20c. LOCATION — City or Town, State <b>Crownsville Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gary L. Kaufman</b>				22. NAME AND ADDRESS OF FACILITY <b>Gary L. Kaufman Funeral Homes 5695 Main St., Elkridge, Md. 21227</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lt. lower lung pneumonia</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF): <b>severe end-stage chronic bronchitis</b>							
c. DUE TO (OR AS A CONSEQUENCE OF): <b>atherosclerotic cardiovascular disease</b>							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature] Physician</b>				29c. LICENSE NUMBER <b>D29869</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/2/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>Stanley L. Gover 5797 Augustine Ave. Baltimore</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>George J. Smith</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 4, 1994</b>		3. TIME OF DEATH <b>8:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>216-30-1569</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>58</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>Apr. 9, 1935</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>1516 Ramsey St.</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
10a. STATE <b>Md.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1516 Ramsey St.</b>				10f. ZIP CODE <b>21223</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Maintenance</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>George H. Smith</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Vola Dimler</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sylvia C. Smith</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1516 Ramsey St., Baltimore, Md. 21223</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Crest Lawn Mem. Gardens 3/08</b>		20c. LOCATION — City or Town, State <b>Sykesville, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY <b>Gary L. Kaufman Funeral Homes 5695 Main St., Elkridge, Md. 21227</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Non-Hodgkins Lymphoma</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>3mos</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DGA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER <b>D19419</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/7/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Spec. Print) <b>DANA H. GRIFFITHS 900 CATON AVE BALT. MD. 21209</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>John H. Scriber</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 23 1994</b>		3. TIME OF DEATH <b>1015 P M</b>	
4. SOCIAL SECURITY NUMBER <b>218-03-2447</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5/23/13</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Sinai</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Hospital</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>md</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Balto</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5110 Balto National Pike</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>8th</b> Elementary/Secondary (0-12) <b>College</b> (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chemical Mixer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>steel</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Louis I. Scriber</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Kate Scriber</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Kit Smithery</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2243 Clove Terrace Balto, md 21209</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>Druid Ridge 2/28/94</b>		20c. LOCATION — City or Town, State <b>Balto, md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jerome A. Thompson Jr</b>				22. NAME AND ADDRESS OF FACILITY <b>March A. H. West ave 4300 Wabash</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>respiratory distress</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>pneumonia</b> c. d. Approximate Interval Between Onset and Death <b>2 weeks</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Bruce J. Kielbaso</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>3/7/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Sinai Hospital of Baltimore</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Rendell</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mary Louise Sherrill</b>				2. DATE OF DEATH MONTH DAY YEAR <b>02-28-1994</b>		3. TIME OF DEATH <b>7:19p</b>	
4. SOCIAL SECURITY NUMBER <b>213-30-5859</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08-12-1920</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital of Balto, Inc.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Md.</b>			
10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>4125 Parkheights Avenue</b>			
10f. ZIP CODE <b>21215</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) <b>12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Frank Wilson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elinore Davenport</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Andrew J. Sherrill</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4125 Parkheights Ave. Baltimore, Md 21215</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or institution, street address, etc.) <b>King Memorial Park 3/5/94</b>		20c. LOCATION — City or Town, State <b>Randallstown, Md.</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>D. B. Caple</b>	
22. NAME AND ADDRESS OF FACILITY <b>Caple Funeral Service</b> <b>5502 Winner Ave. Balto, Md. 21215</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Cardiac Arrest</b> 2/28/94 7:19pm b. <b>Overwhelming sepsis</b> 2/7/94 c. <b>Neutrocytic fascitis</b> d. <b>Renal failure, uremia</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Parshad FOR DR. CHUNG HUA YI</b> <b>9915 (A-PARSHAD)</b>				29c. LICENSE NUMBER <b>9742</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/28/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CHUNG HUA Y, SINAI HOSPITAL, BALTIMORE MD 21209</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <b>John S. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06687

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

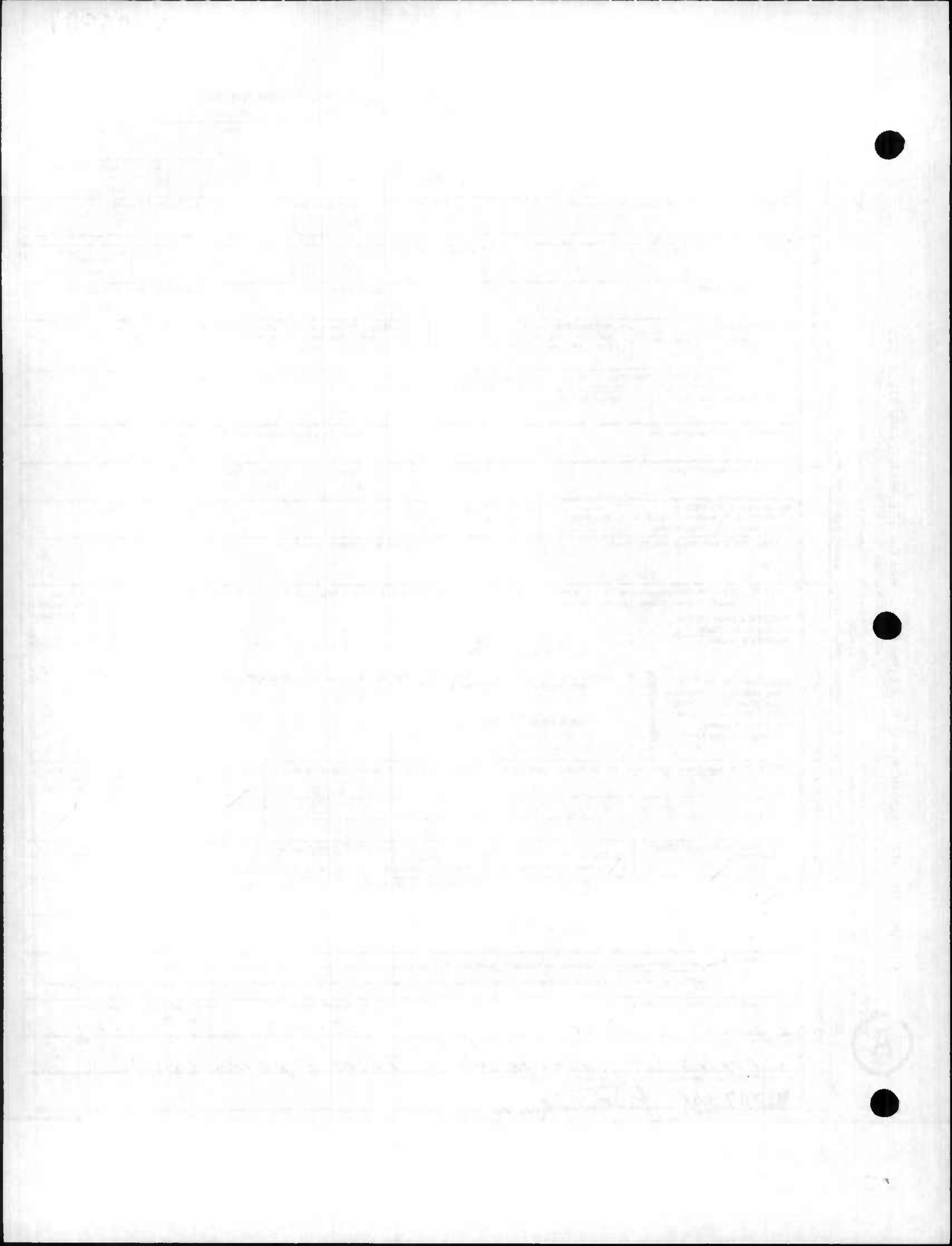
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RICHARD SZEWCAK				2. DATE OF DEATH MONTH DAY YEAR MARCH 3, 1994		3. TIME OF DEATH 7:08 a. M	
4. SOCIAL SECURITY NUMBER 166-42-5078		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 44 YRS.	7. DATE OF BIRTH (Month, Day, Year) November 25, 1949		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE Pennsylvania		10b. COUNTY Philadelphia		10c. CITY, TOWN OR LOCATION Philadelphia		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3976 Stevenson Road				10f. ZIP CODE 19114		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Vietnam		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) General Manager		16b. KIND OF BUSINESS/INDUSTRY Food			
17. FATHER'S NAME (First, Middle, Last) Richard A. Szewczak, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Wixsted			
19a. INFORMANT'S NAME (Type/Print) Mary Szewczak				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3976 Stevenson Road Philadelphia, Pennsylvania 19114			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Calvary Cemetery		DATE 3/8		20c. LOCATION — City or Town, State Conshohocken, Pennsylvania	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY Marzullo Funeral Service 3981 Carrollton Road Upperco, Maryland 21155			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>SEPSIS</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <u>Chronic Myelogenous Leukemia</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 1 week Months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles H. Redfern</i>				29c. LICENSE NUMBER J1419		29d. DATE SIGNED (Month, Day, Year) 3/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles H. Redfern, Johns Hopkins Hosp.							
31. DATE FILED (Month, Day, Year) MAR 07 1994				32. REGISTRAR'S SIGNATURE <i>Justin...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARTHA SIEBERT</b>				2. DATE OF DEATH MONTH <b>2</b> - DAY <b>28</b> - YEAR <b>94</b>		3. TIME OF DEATH <b>9:45 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>212-10-5433</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 29, 1904</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>FALLSTON GEN. Hosp.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>FALLSTON</b>	
9c. COUNTY OF DEATH <b>HARFORD CO.</b>				10a. STATE <b>MD.</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>825 S. KENWOOD AVE.</b>	
10f. ZIP CODE <b>21224</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>HOMEMAKER</b>			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>				17. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>FRANCIS DEMBECK</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FRANCES POTURALSKA</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARTHA SCHULTZ</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1206 MILL CREEK RD FALLSTON MD. 21047</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>CHAPLAIN CEM 3-3-94</b>			
20c. LOCATION — City or Town, State <b>BALTO. CO. MD.</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Thomas J. Skarda Jr.</b>			
22. NAME AND ADDRESS OF FACILITY <b>SKARDA FH 2829 HUDSON ST 21224</b>				23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>acute myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>A.S.C.V.D. &amp; mild CHF</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Acute Bronchitis</b> <b>Left Sided Pleural Effusion</b> <b>Hypothyroidism</b>			
24. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>3-3-94</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Thomas J. Skarda Jr. M.D.</b>				29c. LICENSE NUMBER <b>D02191</b>			
29d. DATE SIGNED (Month, Day, Year) <b>3-2-1994</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ATAOLLAH GOLPIRA, MD., 3029 Dundalk Ave Baltimore, Md 21222</b>			
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06689

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lester Ivins Dinghee Smith</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 2, 1994</b>		3. TIME OF DEATH <b>11:00 a M</b>	
4. SOCIAL SECURITY NUMBER <b>194-18-1320</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>November 28, 1921</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>6204 Bellona Avenue</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Baltimore</b>				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>6240 Bellona Avenue</b>			
10f. ZIP CODE <b>21212</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 years</b> College (1-4 or 5+) <b>4 years</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sales Representative</b>		16b. KIND OF BUSINESS/INDUSTRY <b>American Olean Tile Co.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Henry A. Smith</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helene Johnson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jacqueline J. Smith</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6240 Bellona Ave. Baltimore, MD 21212</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial Gardens March 4</b>		20c. LOCATION — City or Town, State <b>Timonium, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert Michael Kratz</b>				22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Wiedefeld Home Inc. 6500 York Road Baltimore, MD 21212</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Prostate Cancer</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. <b>bone metastases</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Katherine Tkaczuk</b>				29c. LICENSE NUMBER <b>D 36146</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-3-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Katherine Tkaczuk M.D. UMCC 22 SOUTH GREENE ST BALTIMORE MD 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <b>John William Rouse</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ALBERT HENRY SPRINGER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 1, 1994</b>		3. TIME OF DEATH HOURS MINUTES <b>7:25P</b>	
4. SOCIAL SECURITY NUMBER <b>214-03-4536</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. <b>83</b>		7. DATE OF BIRTH (Month, Day, Year) <b>January 31, 1911</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not Institution, give street and number) <b>Dulaney-Towson Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Towson</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>8007 York Road Apt A-7</b>	
10f. ZIP CODE <b>21204</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chauffeur</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Private Hospital</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Albert Springer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Julia Cole</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Katherine Springer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8007 York Road A-7 Towson, Maryland 21204</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Druid Ridge</b>		20c. LOCATION — City or Town, State <b>3/5 Pikesville, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert M. Kratz</b> M00344				22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Wiedefeld Home</b> <b>6500 York Road Baltimore, Maryland 21212</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CVA</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <b>1</b> <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>AS</b>				29c. LICENSE NUMBER <b>D37362</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06691

Item # 1,7 Film # G 709 3-3-94 N.A. Per Funeral Home

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>LORENZA TINSLEY</u> Lorenzo Tyrone Tinsley				2. DATE OF DEATH MONTH DAY YEAR <u>March 2 1994</u>		3. TIME OF DEATH <u>8:45 P M</u>	
4. SOCIAL SECURITY NUMBER <u>217-40-4354</u>		5. SEX 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>48</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>8/11/45</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>HARBOR HOSPITAL</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE, MD</u>		9c. COUNTY OF DEATH <u>n/a</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>MARYLAND</u>		10b. COUNTY <u>n/a</u>		10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>2928 SPELMAN ROAD</u>				10f. ZIP CODE <u>21225</u>		10g. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11 TH</u> College (1-4 or 5+) <u>n/a</u>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>n/a</u>		16b. KIND OF BUSINESS/INDUSTRY <u>n/a</u>			
17. FATHER'S NAME (First, Middle, Last) <u>JOHN TINSLEY</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>MARY LOUISE KENNEY</u>			
19a. INFORMANT'S NAME (Type/Print) <u>EVELYN TINSLEY</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2834 BOOKERT DRIVE, BALTIMORE, MARYLAND 21225</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>GARRISON FOREST VA CEMETERY</u>		DATE <u>March 2 1994</u>		20c. LOCATION — City or Town, State <u>OWINGS MILLS, MD</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>WM. C. MARCH FH. - 1101 E. NORTH AVENUE</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Hepatic Encephalopathy</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <u>Liver failure</u> <u>Renal failure</u> <u>aspiration Pneumonia</u>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Renal failure</u> <u>aspiration Pneumonia</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Raymond Millan</u>				29c. LICENSE NUMBER <u>ASS 2441614-39</u>		29d. DATE SIGNED (Month, Day, Year) <u>March 2/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Raymond Millan 3001 So. Hanover St. Balto MD 21225</u>							
31. DATE FILED (Month, Day, Year) <u>MAR 07 1994</u>		32. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06692

Item # 1,10c Film # G 709 3-7-94 N.A. Per. Funeral Home

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Helen Thornton</u> Helen L. Thornton				2. DATE OF DEATH MONTH <u>3</u> DAY <u>14</u> YEAR <u>1994</u>		3. TIME OF DEATH <u>1:35</u> AM M	
4. SOCIAL SECURITY NUMBER 214-20-3993		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-02-23	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) MERCY MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, MD	
9c. COUNTY OF DEATH n/a				10a. STATE MARYLAND			
10b. COUNTY n/a				10c. CITY, TOWN OR LOCATION BALTIMORE			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 4827 TRUSDALE 4827 Truesdale Ave.			
10f. ZIP CODE 21206				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary <u>4</u> Secondary (9-12) <u>TH</u> College (1-4 or 5+) <u></u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEKEEPING		16b. KIND OF BUSINESS/INDUSTRY UNIVERSITY of MD. HOSPITAL			
17. FATHER'S NAME (First, Middle, Last) HOWARD HUGHES				18. MOTHER'S NAME (First, Middle, Maiden Surname) GRACE HAYES			
19a. INFORMANT'S NAME (Type/Print) HELEN GRINAGE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6616 SPRINGMILL CIRCLE, BALTIMORE, MD 21207			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOU DON PARK CEMETERY 03-08		20c. LOCATION — City or Town, State BALTIMORE CO., MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>See Holland</u>	
22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.- 1101 E. NORTH AVENUE		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>congestive heart failure</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>endocarditis</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Diabetes mellitus</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>hypertension</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <u>Szeluga, MD</u>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 3/4/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Debra Szeluga, MD</u>							
31. DATE FILED (Month, Day, Year) MAR 07 1994		32. REGISTRAR'S SIGNATURE <u>John B. ...</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

EXHIBIT 101

STATE OF NEW YORK

IN SENATE

January 1, 1911

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1909  
RELATIVE TO THE  
LANDS BELONGING TO THE STATE

Item # 1 file # G 709 3-7-94 N.A. Per. funeral Home

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

1. DECEDENT'S NAME (First, Middle, Last) <b>Dolores Thompson</b>		2. DATE OF DEATH MONTH <b>3</b> DAY <b>2</b> YEAR <b>94</b>		3. TIME OF DEATH <b>1:01 A</b>	
4. SOCIAL SECURITY NUMBER <b>216-30-8674</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>58</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>10-28-35</b>		8. BIRTHPLACE (State or Foreign Country)			
9a. FACILITY NAME (If not institution, give street and number) <b>Mercy Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore, MD</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT					
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>6616 Bushey Street</b>		10f. ZIP CODE <b>21224</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Waitress</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Calmas Pizza</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Hobert Carr</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Daisy Showalter</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Marlene Braden</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6616 Bushey St. Baltimore, MD 21224</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Carmel Cemetery 3/4</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Elizabeth Salenki</b>		22. NAME AND ADDRESS OF FACILITY <b>Lilly &amp; Zeiler, Inc. Funeral Home 1901 Eastern Avenue Balto., MD 21231</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ARDS</b> <b>Septic Shock</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>ARDS</b> <b>Septic Shock</b>					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Chesno</b>					29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year) <b>3/3/94</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>301 St. Paul St Baltimore, MD 21202</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>					32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>





94 06695

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>MICAH TERRELL</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>16</b> YEAR <b>94</b>		3. TIME OF DEATH <b>10:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>N/A</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>3</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3/25/1990</b>	
8. BIRTHPLACE (State or Foreign Country) <b>BALTO., MD</b>				9a. FACILITY NAME (If not institution, give street and number) <b>UNIV. OF MARYLAND MED. SYSTEM</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>619 EDGEWOOD STREET</b>	
10f. ZIP CODE <b>21229</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>N/A</b>		15b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>	
17. FATHER'S NAME (First, Middle, Last) <b>CEDRIC TERRELL</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ROSLYNN GLOVER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>WILLIAM HOPKINS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4304 ROLAND SPRING DR. BALTO., MD 21210</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK</b>		20c. LOCATION — City or Town, State <b>RANDALLSTOWN, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY <b>LEROY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207</b>			
23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Respiratory Failure</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. Adult Respiratory Distress Syndrome, Sepsis</b> <b>c. Smoke Inhalation, Bronchopulmonary fistula</b> <b>d. 2° + 3° burns, 15%, face, neck, upper limbs</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				27. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
28a. DATE OF INJURY (Month, Day, Year) <b>11/9/94</b>				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>House Fire</b>				28e. PLACE OF INJURY — home, farm, street, factory, office building, etc. (Specify) <b>home</b>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joel Rubenstein MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>2/28/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Joel Rubenstein</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RUTH YOUNG TRAYNOR				2. DATE OF DEATH MONTH 3 DAY 2 YEAR 94		3. TIME OF DEATH 8:20 pm M	
4. SOCIAL SECURITY NUMBER 219-03-9453		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 16, 1919	
9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT				10a. STATE Maryland		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 2000 Ramblewood Road				10f. ZIP CODE 21239		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Medical Supply			
17. FATHER'S NAME (First, Middle, Last) Archibald A. Young				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel Patterson Barnes			
19a. INFORMANT'S NAME (Type/Print) Carol T. Malarky				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10301 West 121st Street Overland Park Kansas 66213			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest Burial Park		20c. DATE 3/7		20d. LOCATION — City or Town, State Cumberland Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dennis Stephen Xenakis MD0640				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. LIVER FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. METASTATIC VAGINAL CA. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Beth R. Schwartz MD				29c. LICENSE NUMBER D38352		29d. DATE SIGNED (Month, Day, Year) 3/3/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Beth R. Schwartz, M.D. - GBMC - 6701 N. Charles St; Towson MD 21204							
31. DATE FILED (Month, Day, Year) MAR 07 1994				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RAMON TURNER</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>28</b> YEAR <b>94</b>		3. TIME OF DEATH <b>6:05 a M</b>	
4. SOCIAL SECURITY NUMBER <b>216-07-4922</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>September 9, 1901</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>Greater Baltimore Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Timonium</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2004 Dumont Road</b>				10f. ZIP CODE <b>21093</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 8+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Contract Representative</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Bendix Manufacturing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Turner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Idabel Connor</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joseph G. Staffone</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2004 Dumont Road Timonium Maryland 21093</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Louisa Park Cemetery</b>		DATE <b>3/1</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dennis Stephen Xenakis</i> <b>Dennis Stephen Xenakis</b> M00640				22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Wiedefeld Home</b> <b>6500 York Road Baltimore, Maryland 21212</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Isolated pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. <i>Operations</i> DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Massive GI bleed. Ischemic colitis</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marjose M.D.</i> <b>MARJOSE M.D.</b>				29c. LICENSE NUMBER <b>D25171</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/28/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ALVARO JEREZ 1205 Fork Rd Futhersville Md 21093</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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*[Faint, illegible text and markings on lined paper, possibly bleed-through from the reverse side.]*



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANNIE WILEY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 2, 1994</b>		3. TIME OF DEATH <b>8:35 P M</b>	
4. SOCIAL SECURITY NUMBER <b>216-16-9647</b>		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>2-13-1919</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>MD</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>BALTO</b>		10c. CITY, TOWN OR LOCATION <b>BALTO</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3627 #2 VALLEY TERRACE</b>				10f. ZIP CODE <b>21244</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+) <b>UNKNOWN</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNKNOWN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>SEARS &amp; ROEBUCK</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ERNEST STERLING</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SERENA</b>			
19a. INFORMANT'S NAME (Type/Print) <b>SERENA WILEY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3627 VALLEY TERRACE #2 BALTO, MD 21244</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>KING MEMORIAL PARK 3894</b>		20c. LOCATION — City or Town, State <b>RANDALLSTOWN, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jerome A. Thompson Jr.</i>				22. NAME AND ADDRESS OF FACILITY <b>MARCH F/H-WEST 4300 WABASH AVE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lower Gastrointestinal bleed</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Ischemic bowel</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Aortic Type B Dissection</b> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>7 hours</b> <b>7 hours</b> <b>7 weeks</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Rheumatoid Arthritis, Renal failure, NIDDM, T12 Paraplegia, atrial fibrillation</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Audrey HO, MD</i>				29c. LICENSE NUMBER <b>41017</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/2/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>AUDREY HO MD., THE JHH., 600 N WOLFE STREET, BALTIMORE, MD. 21287</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STYLING ROOM

12154

MAR 6 1954



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELMER JAMES WALKER SR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March First, 1994</b>		3. TIME OF DEATH <b>4:21 A M</b>	
4. SOCIAL SECURITY NUMBER <b>215-03-9505</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 27, 1916</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>Maryland</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Hillendale</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>1 Debonair Ct. Apt. A-2</b>			
10f. ZIP CODE <b>21234</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5 + years</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>School Teacher</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Baltimore County Public</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Elmer Daniel Walker</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) <b>Ruth T. Walker</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 Debonair Ct. Apt. A-2 Balto. Maryland 21234</b>			
20. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Most Holy Redeemer Cemetery 3-4</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>George J. Ferrarse</b>	
22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Wiedefeld Home</b> <b>6500 York Road Baltimore, Maryland 21212</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b>							
Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>Metastatic Lung CA</b> DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary artery dz.</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)		28e. DESCRIBE NOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>M.D.</b>		29c. LICENSE NUMBER <b>AT2438946</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/1/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Jay Zwally II M.D. Union Memorial Hospital</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>		32. REGISTRAR'S SIGNATURE <b>Jake Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06700

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MELVIN C. ABE				2. DATE OF DEATH MONTH DAY YEAR Feb. 17 1994				3. TIME OF DEATH 2210 M		
4. SOCIAL SECURITY NUMBER 214-05-9400		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	7. DATE OF BIRTH (Month, Day, Year) Mar 12, 1914		8. BIRTHPLACE (State or Foreign Country) WV				
9a. FACILITY NAME (If not institution, give street and number) Allegany County Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND			9c. COUNTY OF DEATH ALLEGANY			
10a. STATE WV			10b. COUNTY Mineral		10c. CITY, TOWN OR LOCATION Ridgeley			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER Route 3				10f. ZIP CODE 26753		10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (14 or 5+) College			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) construction supervisor			16b. KIND OF BUSINESS/INDUSTRY Construction				
17. FATHER'S NAME (First, Middle, Last) Hiram N. Abe				18. MOTHER'S NAME (First, Middle, Maiden Surname) Effie Catlett						
19a. INFORMANT'S NAME (Type/Print) Ronald Abe				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 3 Box 101; Clearville, PA 15535						
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematorium		20c. DATE 2/18		20d. LOCATION — City or Town, State Smithsburg, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metabolic C of Colon</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alcohol, Cocaine</i>									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>N.A. Ranjithan MD</i>				29c. LICENSE NUMBER D19318			29d. DATE SIGNED (Month, Day, Year) 2/18/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. VIMALA RANJITHAN (for) Oldtown Road, Cumberland, MD 21502										
31. DATE FILED (Month, Day, Year) FEB 23 1994				32. REGISTRAR'S SIGNATURE <i>John S. ...</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transmit form. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

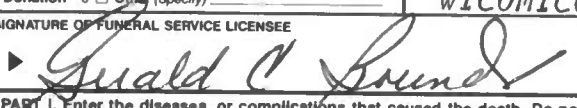


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06701

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELSIE WARD ARDIS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 12 1994</b>		3. TIME OF DEATH <b>5:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214-10-8772</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-17-1906</b>	
6a. FACILITY NAME (If not institution, give street and number) <b>BERLIN NURSING HOME</b>				6b. CITY, TOWN OR LOCATION OF DEATH <b>BERLIN</b>		6c. COUNTY OF DEATH <b>WORCESTER</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD.</b>		10b. COUNTY <b>WICOMICO</b>		10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>115 CIVIC AVENUE</b>				10f. ZIP CODE <b>21801</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>SOLOMON WARD</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARTHA BRIMER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>BETTY TILGHMAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>202 COULBOURNE DRIVE, SNOWHILL, MD. 21863</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WICOMICO MEM. PARK 2-16 SALISBURY, MD.</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>BOUNDS FUNERAL HOME, SALISBURY, MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary Arteriosclerosis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Diffuse Arteriosclerosis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>MI</b> DUE TO (OR AS A CONSEQUENCE OF): <b></b> DUE TO (OR AS A CONSEQUENCE OF): <b></b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>yes</b> <b>yes</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Recent cholecystomy &amp; Resection of the liver</b> <b>Sept 11, 93</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D02026</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-14-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Federico G. Arthes 1622A Ocean Pines Berlin, MD 21811 410-641-4400</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 15 1994</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>GRAYSON L. ABBOTT</u>				2. DATE OF DEATH MONTH <u>02</u> DAY <u>11</u> YEAR <u>94</u>				3. TIME OF DEATH <u>1157</u> M	
4. SOCIAL SECURITY NUMBER <u>230-07-3605</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>74</u> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____	
9a. FACILITY NAME (If not institution, give street and number) <u>PENINSULA REGIONAL MEDICAL CENTER</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>SALISBURY</u>				9c. COUNTY OF DEATH <u>WICOMICO</u>	
RESIDENCE OF DECEDENT									
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Wicomico</u>		10c. CITY, TOWN OR LOCATION <u>Salisbury</u>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>3848 Pocomoke Rd.</u>				10f. ZIP CODE <u>21801</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>9</u> College (1-4 or 5+) <u>0</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Self employed</u>			16b. KIND OF BUSINESS/INDUSTRY <u>Poultry</u>		
17. FATHER'S NAME (First, Middle, Last) <u>Bertie (unk) Abbott</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Mamie (unk) Costen</u>					
19a. INFORMANT'S NAME (Type/Print) <u>Bessie M. Abbott</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3848 Pocomoke Rd., Salisbury, MD 21801</u>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Olivet Cemetery</u>		DATE <u>2/15</u>		20c. LOCATION — City or Town, State <u>Worcester Co., MD</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>Holloway Funeral Home</u> <u>501 Snow Hill Rd., Salisbury, MD 21801</u>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
a. <u>Cardiopulmonary Arrest - (unwitnessed)</u> DUE TO (OR AS A CONSEQUENCE OF):									
b. <u>Coronary artery disease &amp; non-transmural</u> DUE TO (OR AS A CONSEQUENCE OF):									
c. <u>myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF):									
d.									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Calcific Aortic Stenosis, chronic R.A., severe COPD - BRONCHIECTASIS, PNEUMONIA, old CVA, peptic ulcer disease</u>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M _____		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>				29c. LICENSE NUMBER <u>018614</u>		29d. DATE SIGNED (Month, Day, Year) <u>2.11.94</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Deepak Sagar 547 E Riverside Dr Salisbury MD 21801</u>									
31. DATE FILED (Month, Day, Year) <u>FEB 15 1994</u>		32. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1891

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GLADYS M. BOYD				2. DATE OF DEATH MONTH 02 DAY 20 YEAR 1994		3. TIME OF DEATH 7:35 am	
4. SOCIAL SECURITY NUMBER 213-16-8688		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08-16-1922	
8. BIRTHPLACE (State or Foreign Country) Md.				9a. FACILITY NAME (If not institution, give street and number) McCready Foundation, Inc.		9b. CITY, TOWN OR LOCATION OF DEATH Crisfield	
9c. COUNTY OF DEATH Somerset				10a. STATE MD			
10b. COUNTY Somerset				10c. CITY, TOWN OR LOCATION Crisfield			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 64 SOMERS COVE			
10f. ZIP CODE 21817				10g. CITIZEN OF WHAT COUNTRY? U.S.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY SEA Food	
17. FATHER'S NAME (First, Middle, Last) Samuel M. Horsey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Johnson			
19a. INFORMANT'S NAME (Type/Print) Louise V. Butler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 90 P.O. Main St. Crisfield Md. 21817			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hopewell Crem. 2-26-94 Hopewell Md.		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Anthony Ward Funeral Home/Cove St. Crisfield, Md. 21817				22. NAME AND ADDRESS OF FACILITY			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ISCHEMIC CARDIOMYOPATHY WITH FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. ARTERIOSCLEROTIC HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. GENERALIZED ARTERIOSCLEROSIS DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 DAYS 3 YRS 10 YRS Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC DIABETIC RENAL DISEASE INSULIN DEPENDENT DIABETES MELLITUS							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Gregorio Belloso MD				29c. LICENSE NUMBER D29505		29d. DATE SIGNED (Month, Day, Year) 2-21-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gregorio Belloso, MD 4421 Beechwood Pl. Crisfield, Md. 21817							
31. DATE FILED (Month, Day, Year) FEB 24 '94				32. REGISTRAR'S SIGNATURE John Davidson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

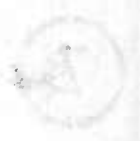
DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FLOYD BUSER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 13, 1994</b>		3. TIME OF DEATH <b>1:35 P M</b>	
4. SOCIAL SECURITY NUMBER <b>215-36-9770</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug 1, 1908</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>MD</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Oldtown</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>Route 1 Box 103</b>			
10f. ZIP CODE <b>21555</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (8-12)</b> <b>12</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>farmer</b>		15b. KIND OF BUSINESS/INDUSTRY <b>farming</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Thomas Henry Buser</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lurena Mae Boggs</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ruth E. Hodel</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Oldtown, MD 21555</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Davis Memorial Cemetery 02-17</b>		20c. LOCATION — City or Town, State <b>Cumberland, MD</b>		20d. DATE <b>02-17</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CVA (stroke)</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <b>CHF</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>DM</b> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Vik Poonai M.D.</b>				29c. LICENSE NUMBER <b>D 36766</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/14/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Vik Poonai M.D. P.O. Box 338 Cumberland MD 21501</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 17 1994</b>		REGISTRAR'S SIGNATURE <b>John Harrison-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate.



IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edna Adele Bond				2. DATE OF DEATH MONTH DAY YEAR 02 15 94		3. TIME OF DEATH 1:30 A.M.		
4. SOCIAL SECURITY NUMBER 214-48-2902		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 7, 1902		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Goodwill Mennonite Home				9b. CITY, TOWN OR LOCATION OF DEATH Grantsville		9c. COUNTY OF DEATH Garrett		
RESIDENCE OF DECEDENT								
10a. STATE Maryland		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION McHenry		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER Route 2, Box 267				10f. ZIP CODE 21541		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home				
17. FATHER'S NAME (First, Middle, Last) George F. Ault				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rebecca Durst				
19a. INFORMANT'S NAME (Type/Print) Louise M. Bond				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Star Route 1, Box 187; McHenry, Maryland 21541				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Grove Cemetery 2/17		20c. LOCATION — City or Town, State McHenry, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Newman Funeral Homes, P.A. Grantsville, Maryland 21536				
23. PART I. Enter the diseases, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio respiratory failure. b. Coronary Artery Disease. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. d. e. f. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Dementia.							Approximate interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER James E. Beitzel MD				29c. LICENSE NUMBER D34079		29d. DATE SIGNED (Month, Day, Year) 02-16-94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James E. Beitzel MD Grantsville MD								
31. DATE FILED (Month, Day, Year) FEB 24 1994 REGISTRAR'S SIGNATURE 								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MATTIE BAILEY BLUNT</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>14</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>1:40 P</b>	
4. SOCIAL SECURITY NUMBER <b>2 1 3-3 4 -3420</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>100</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-11-1893</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>WATERVIEW HEALTH CARE CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO md.</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD.</b>		10b. COUNTY <b>WICOMICO</b>		10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>JOHN B. PARSONS HOME</b>				10f. ZIP CODE <b>21801</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HOMEMAKER</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		15b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN C. BAILEY</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EMMA VIRGINIA BANKS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>KATHERINE McDONALD</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1400 WOODLAND ROAD, SALISBURY, MARYLAND 21801</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>ST. PHILLIPS CHURCH YARD</b>		20c. DATE <b>2/16</b>		20d. LOCATION — City or Town, State <b>QUANTICO, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gerald C. Bounds</b>				22. NAME AND ADDRESS OF FACILITY <b>Bounds Funeral Home, Salisbury, Md</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>ATHEROSCLEROTIC CARDIO VASCULAR DISEASE</b>					
		b. <b>DEHYDRATION</b>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arrhythmia</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Maresh Moondra</b>		29c. LICENSE NUMBER <b>D32014</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/14/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARESH MOONDRA 547E Riverside &amp; Salisbury MD</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 15 1994</b>		32. REGISTRAR'S SIGNATURE <b>Juha Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5-10-1954

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10-10-1954

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10-10-1954



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Maynard BROWN</i>				2. DATE OF DEATH MONTH DAY YEAR <i>February 19, 1994</i>		3. TIME OF DEATH M <i>0020</i>	
4. SOCIAL SECURITY NUMBER <i>222-10-8571</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>73</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>9-9-1921</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>PENINSULA REGIONAL MEDICAL CENTER</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>SALISBURY</i>		9c. COUNTY OF DEATH <i>WICOMICO</i>	
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION <i>Milford</i>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10a. STATE <i>Delaware</i>		10b. COUNTY <i>Kent</i>		10f. ZIP CODE <i>19963</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
10e. STREET AND NUMBER <i>413 N.E. Front St.</i>				10f. ZIP CODE <i>19963</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>8th</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Apprentice</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Milford Chronicle Newspaper</i>			
17. FATHER'S NAME (First, Middle, Last) <i>George M. Brown</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Susie Boyer</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Carrie P. Brown</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>413 N.E. Front St. Milford, DE. 19963</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Old Hickory Cemetery 2-94</i>		DATE <i>Lincoln, DE.</i>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Clarence E. Young</i>				22. NAME AND ADDRESS OF FACILITY <i>309 North St. Young's Funeral Homes Milford, DE. 19963</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Atherosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <i>4 hours</i>  <i>10 years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Redo CORONARY ARTERY Bypass procedure</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Julian MD</i>				29c. LICENSE NUMBER <i>D41813</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/10/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>J. Steve Julian MD 201 Pine Bluff Rd Salisbury MD 21801</i>							
31. DATE FILED (Month, Day, Year) <i>FEB 16 1994</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

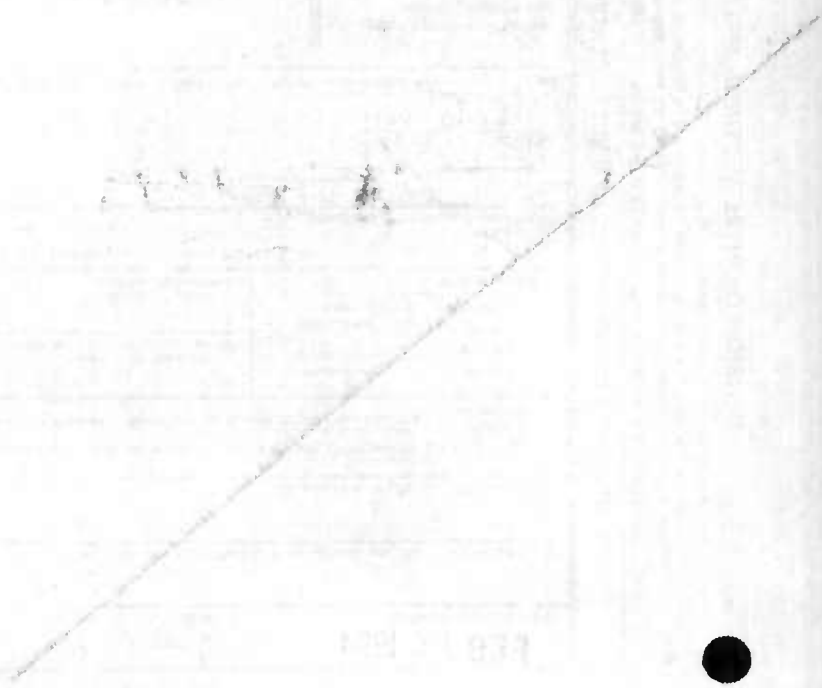
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5



100 1 034

Admended Items # 7,10 b,c,d,e,f, Wic. Co. 2-16-94 jrd

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Elnora Bivens</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>11</b> YEAR <b>94</b>		3. TIME OF DEATH <b>7:55 A M</b>	
4. SOCIAL SECURITY NUMBER <b>216-30-6858</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>97</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept 9, 1896</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. FACILITY NAME (If not institution, give street and number) <b>Wicomico Nursing Home</b>			
10. STATE <b>Maryland</b>				10b. COUNTY <b>SOMERSET</b>		10c. CITY, TOWN OR LOCATION <b>Salisbury</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>900 Booth St. Box 206</b>			
10f. ZIP CODE <b>21801 21816</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>n/a</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Seafood Processor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Seafood</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Parker</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Clara Parker</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gary Handy</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>332 Martingale Ave., Baltimore, MD 21229</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State <b>Salisbury, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Lewis N. Watson Funeral Home</b> <b>1618 West Rd., Salisbury, MD 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Terminal Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Senility</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Mentally Incompetent</b> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate interval between Onset and Death <b>20 days</b> <b>1 year</b> <b>1 year</b> <b>1 year</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D2026</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-12-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>F.G. Arthes, MD 1622 A Ocean Pines, Berlin, Md. 21811</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 16 1994</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

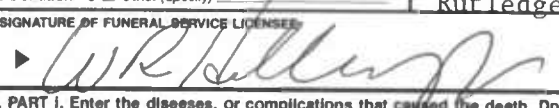
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELSIE JACQUELINE BAILEY				2. DATE OF DEATH MONTH 02 DAY 11 YEAR 94				3. TIME OF DEATH 8:20 AM		
4. SOCIAL SECURITY NUMBER 423-10-5539		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02/12/13		8. BIRTHPLACE (State or Foreign Country) Alabama		
9a. FACILITY NAME (If not institution, give street and number) 405 Valleywood Dr.				9b. CITY, TOWN OR LOCATION OF DEATH Salisbury				9c. COUNTY OF DEATH Wicomico		
RESIDENCE OF DECEDENT										
10a. STATE Maryland		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 405 Valleywood Dr.				10f. ZIP CODE 21801				10g. CITIZEN OF WHAT COUNTRY? U.S.A		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY None		
17. FATHER'S NAME (First, Middle, Last) Starling Jackson Morris				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Thrower						
19a. INFORMANT'S NAME (Type/Print) Faye Marriner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Valleywood Dr. Salisbury, Md. 21801						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rutledge Cemetery				DATE 2/14		20c. LOCATION — City or Town, State Laverne, Alabama		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home P. A. Salisbury, Md.						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>LUNG CANCER</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									Approximate Interval Between Onset and Death 8 MONTHS	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER Paul R. Henry MD				29c. LICENSE NUMBER D24872				29d. DATE SIGNED (Month, Day, Year) 2/14/94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 560 Riverside Dr 204 A - Salisbury Md 21801										
31. DATE FILED (Month, Day, Year) FEB 17 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN E. BURROUGHS</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>25</b> YEAR <b>94</b>		3. TIME OF DEATH <b>9:00AM</b> M	
4. SOCIAL SECURITY NUMBER <b>577-01-6652</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08 21 17</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Washington DC</b>				9a. FACILITY NAME (If not institution, give street and number) <b>2409 Lackawanna Street</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Adelphi</b>	
9c. COUNTY OF DEATH <b>Prince George's</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prine George's</b>	
10c. CITY, TOWN OR LOCATION <b>Adelphi</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>2409 Lackawanna Street</b>	
10f. ZIP CODE <b>20783</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Police Officer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Law Enforcement</b>	
17. FATHER'S NAME (First, Middle, Last) <b>James A. Burroughs</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Blanche Norris</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary Elizabeth Burroughs</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2409 Lackawanna Street Adelphi, Md. 20783</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Francis Xavier Cem.</b>		20c. LOCATION — City or Town, State <b>Gettysburg, Pa.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Clarence E. Wilson</b>				22. NAME AND ADDRESS OF FACILITY <b>Clarence E. Wilson East Main St. Fairfield, Pa. 17320</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardiopulmonary Arrest</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>b. Coronary Artery Disease</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Howard S. Goldstein</b>				29c. LICENSE NUMBER <b>D-20388</b>		29d. DATE SIGNED (Month, Day, Year) <b>02-25-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Howard S. Goldstein, M.D., 4701 Randolph Rd. Suite 105 Rockville, Md</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <b>Jane Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FRANCES</b>				2. DATE OF DEATH MONTH <b>FEBRUARY</b> DAY <b>19</b> , YEAR <b>1994</b>				3. TIME OF DEATH <b>15:00</b> M	
4. SOCIAL SECURITY NUMBER <b>190-24-1565</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7. DATE OF BIRTH (Month, Day, Year) <b>8/7/33</b>				8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Aberdeen</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>407-A Clover Street</b>				10f. ZIP CODE <b>21001</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>In home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Matthew J. Lopinto</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine Corso</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Valli A. Hylton</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RD3 Box BW15, Felton, Delaware, 19943</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harford Memorial Gardens</b>		DATE <b>2/23</b>		20c. LOCATION — City or Town, State <b>Aberdeen, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harry R. Di Giovanni</i>				22. NAME AND ADDRESS OF FACILITY <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Hepatic Failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Gram negative Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Shunt thrombosis</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Renal Failure</b>								Approximate Interval Between Onset and Death <b>2 months</b> <b>3 days</b> <b>3 days</b> <b>2 days</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>muscle bleed</b>								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Shawn T. Mast M.D.</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>2/19/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Shawn T. Mast M.D. 110 Johns Hopkins Hosp.</b>									
31. DATE FILED (Month, Day, Year) <b>FEB 24 '94</b>		32. REGISTRAR'S SIGNATURE <i>John A. ...</i>							

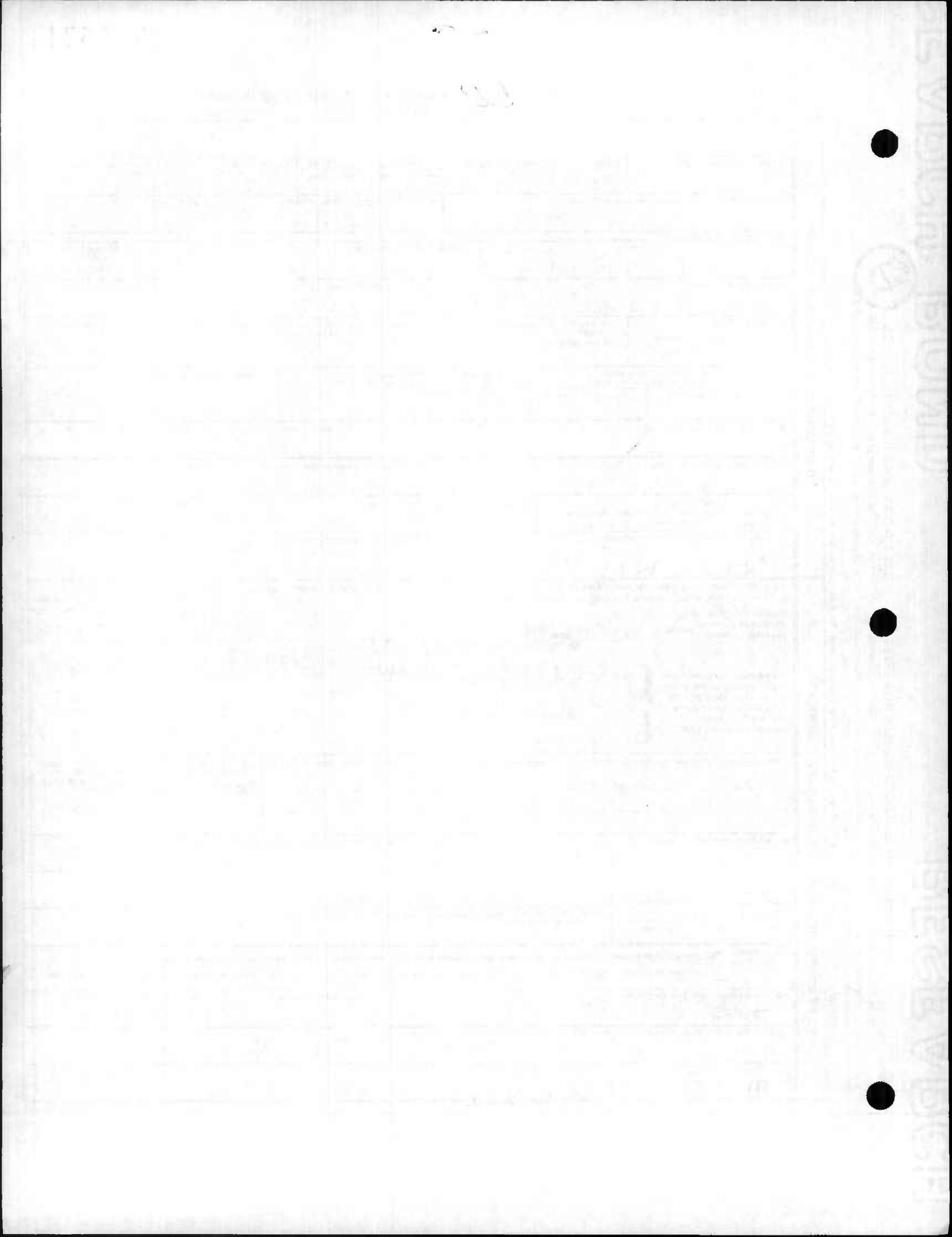
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06712

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JENNINGS BRYAN CORBIN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 20, 1994</b>		3. TIME OF DEATH <b>02:18 A M</b>	
4. SOCIAL SECURITY NUMBER <b>220-10-5710</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>DEC 2 1908</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital &amp; Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ALLEGANY</b>		10c. CITY, TOWN OR LOCATION <b>CUMBERLAND</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>410 BROADWAY</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWI</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>LABORER-OIL RIG</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>LABORER-OIL RIG</b>		16b. KIND OF BUSINESS/INDUSTRY <b>LABORER-OIL RIG</b>			
17. FATHER'S NAME (First, Middle, Last) <b>THOMAS CORBIN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SALLY (UNK) CORBIN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JACQUELINE R. REDMAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>134 ARCH STREET CUMBERLAND MARYLAND 21502</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ROCKY GAP VETS CEMETERY FEB 23 1994 FLINTSTONE MARYLAND</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY <b>MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Dehydration / Malnutrition</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Advanced Carcinoma of lung</b>  Approximate Interval Between Onset and Death <b>&gt; 23 months</b> <b>&lt; 1 year</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>MO</i>				29c. LICENSE NUMBER <b>D23371</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/20/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Q. Zaman Johnson Heights Medical Bldg., Cumberland MD. 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>				32. REGISTRAR'S SIGNATURE <i>John Benner-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0026

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06713

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES DANIEL CALLIS</b>				2. DATE OF DEATH MONTH <b>FEBRUARY</b> DAY <b>15</b> YEAR <b>94</b>				3. TIME OF DEATH <b>6:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>217-10-5905</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug 1, 1918</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND, MD</b>				9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Route 2 Box 459-Williams Road</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>retired</b>				16b. KIND OF BUSINESS/INDUSTRY <b>state highway adm.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charles B. Callis</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bessie E. (Horchler)</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Lee Ann Callis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Route 2 Box 459-Williams Cumberland MD 21502</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hillcrest Burial Park</b>				DATE <b>2/19/</b>		20c. LOCATION — City or Town, State <b>Cumberland MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, Maryland 21502</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>COR PULMONALE</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>HYPOXEMIA</b> <b>EMPHYSEMA</b> <b>ASTHMATIC BRONCHITIS</b>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>STERIOD DEPENDENCE</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <b>DR. JAMES RAVER</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. JAMES RAVER MEMORIAL HOSPITAL CUMBERLAND, MD 21502</b>								29c. LICENSE NUMBER <b>2018764</b>	
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>								32. REGISTRAR'S SIGNATURE <b>James F. Scarpelli</b>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>William E. Cassell</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 18, 1994</b>		3. TIME OF DEATH <b>3:55 p. m.</b>	
4. SOCIAL SECURITY NUMBER <b>218-12-5733</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 17, 1924</b> MD	
9a. FACILITY NAME (If not institution, give street and number) <b>34 Browning Street</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>34 Browning Street</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>salesman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>insurance</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Edward David Cassell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Florine (nmn)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Janet Cassell</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>34 Browning Street Cumberland MD 21502</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sunset Memorial Park 2/22/ Cumberland MD</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Scarpelli</b>		22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, Maryland 21502</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Chronic obstructive lung disease</b> <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Richard G. Schmitt</b>				29c. LICENSE NUMBER <b>026333</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/23/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Richard G. Schmitt, 900 Seton Drive, Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>				32. REGISTRAR'S SIGNATURE <b>John D. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 06715

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Marion B. Close</b>				2. DATE OF DEATH MONTH <b>Feb.</b> DAY <b>16</b> YEAR <b>1994</b>				3. TIME OF DEATH <b>7:05 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>219-36-7603</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>90</b> YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		7. DATE OF BIRTH (Month, Day, Year) <b>May 23, 1903</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>				10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1111 University Blvd W.</b>	
10f. ZIP CODE <b>20902</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Teacher</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Education</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John D. Close</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Baker</b>				19a. INFORMANT'S NAME (Type/Print) <b>John D. Close</b>	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>240 W. Mechanic St. Frostburg, Md. 21532</b>				20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Smithsburg Crematory 2/17/94</b>	
20c. LOCATION — City or Town, State <b>Smithsburg, Md.</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John P. Horn</i>				22. NAME AND ADDRESS OF FACILITY <b>57 Frost Ave. Durst Funeral Home, Frostburg, Md. 21532</b>	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <b>Atrial Fibrillation</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M _____		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sudhakar, MD</i>				29c. LICENSE NUMBER <b>D35792</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-18-94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Swaroop Sudhakar, M.D., 50 W. Edmonston Dr. #504, Rockville, Md. 20852</b>									
31. DATE FILED (Month, Day, Year) <b>FEB 24 1994</b>				32. REGISTRAR'S SIGNATURE <i>John D. Close</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06716

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RAY BUTLER CARDER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>02 23 94</b>		3. TIME OF DEATH <b>7:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214 07 3915</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Mar 20, 1906</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>WV</b>		10b. COUNTY <b>Mineral</b>		10c. CITY, TOWN OR LOCATION <b>Ridgeley</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Route 2 Box 332</b>				10f. ZIP CODE <b>26753</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>retired</b>		16b. KIND OF BUSINESS/INDUSTRY <b>electrical workers</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Albert Lee Carder</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Jane (Watson)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gloria Shillingburg</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Westernport, MD 21540</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Wesley Chapel Cemetery 2/27/</b>		20c. LOCATION — City or Town, State <b>Points WV</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, Maryland 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RENAL FAILURE</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>ACUTE LEUKEMIA</b>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>GI Bleed</b> <b>Myelo fibrosis</b>							Approximate Interval Between Onset and Death <b>2 days</b> <b>1 wk</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul J. Livengood MD</i>				29c. LICENSE NUMBER <b>D23774</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-24-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PAUL LIVENGOOD, M.D. BMG 912 SETON DRIVE CUMBERLAND, MD. 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 25 1994</b>				32. REGISTRAR'S SIGNATURE <i>John S. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Thalia Merritt Carpenter</i>				2. DATE OF DEATH MONTH DAY YEAR <i>February 18, 1994</i>		3. TIME OF DEATH HOURS MINUTES <i>0645</i> M	
4. SOCIAL SECURITY NUMBER <i>228-18-2178</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>82</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Jan. 22, 1912</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Virginia</i>				9a. FACILITY NAME (If not institution, give street and number) <i>PENINSULA REGIONAL MEDICAL CENTER</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>SALISBURY</i>	
9c. COUNTY OF DEATH <i>WICOMICO</i>				10a. STATE <i>Virginia</i>		10b. COUNTY <i>Accomack</i>	
10c. CITY, TOWN OR LOCATION <i>Chincoteague</i>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>6579 Church Street</i>	
10f. ZIP CODE <i>23336</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Self</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Grover Merritt</i>				18. MOTHER'S NAME (First, Middle, Maiden, Surname) <i>Elizabeth Birch</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Curtis J. Carpenter, Jr.</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, and Code) <i>6573 Church Street, Chincoteague, Virginia 23336</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or place of burial) <i>John Taylor Cemetery</i>		20c. LOCATION — City or Town, State <i>Temperanceville, Va.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Constance Salyn Gordon</i>				22. NAME AND ADDRESS OF FACILITY <i>Salyn Funeral Home Chincoteague, Virginia 23336</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Mesenteric Thrombosis</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David C. Kerrigan, M.D.</i>				29c. LICENSE NUMBER <i>D44688</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/18/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>David C. Kerrigan, 560 Riverside Dr. Suite A206, Salisbury, MD 21801</i>							
31. DATE FILED (Month, Day, Year) <i>FEB 22 1994</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MAURICE AVERY</b>				2. DATE OF DEATH MONTH <b>February</b> DAY <b>10</b> YEAR <b>1994</b>				3. TIME OF DEATH <b>1640</b> M	
4. SOCIAL SECURITY NUMBER <b>218-20-3193</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 28, 1914</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>				9c. COUNTY OF DEATH <b>WICOMICO</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Fruitland</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>104 S. Dulany Ave.</b>				10f. ZIP CODE <b>21826</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (13-16 or 5+) <b>0</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Truck driver</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Food</b>		
17. FATHER'S NAME (First, Middle, Last) <b>Grover Cleve Carmine</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary (unk) Ruark</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Barbara Banks</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6631 Winterplace Pkwy., Salisbury, MD 21801</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Springhill Memory Gardens 2/14</b>			20c. LOCATION — City or Town, State <b>Hebron, MD</b>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): <b>Coronary Artery Disease</b> c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death <b>weeks</b> <b>yrs.</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b> <b>Cerebrovascular Accident</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Benito S. Chan MD</b>				29c. LICENSE NUMBER <b>D-20050</b>			29d. DATE SIGNED (Month, Day, Year) <b>2/10/94</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BENITO S. CHAN 547-D Riverside Dr. Salisbury, MD 21801</b>									
31. DATE FILED (Month, Day, Year) <b>FEB 15 1994</b>				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Tamara Bundick Cottman</u>				2. DATE OF DEATH MONTH <u>1</u> DAY <u>29</u> YEAR <u>94</u>		3. TIME OF DEATH <u>10 05</u> P M	
4. SOCIAL SECURITY NUMBER <u>None</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. <u>5</u>		7. DATE OF BIRTH (Month, Day, Year) <u>1/24/94</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>University of Maryland Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		9c. COUNTY OF DEATH <u>Balt. City</u>	
10a. STATE <u>MD</u>				10b. COUNTY <u>Wicomico</u>		10c. CITY, TOWN OR LOCATION <u>Salisbury</u>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <u>904 West Main Street</u>			
10f. ZIP CODE <u>21801</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>0</u> College (1-4 or 5+) <u>0</u>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>n/a</u>		15b. KIND OF BUSINESS/INDUSTRY <u>n/a</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Edwin Cottman</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Marcia Bundick</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Barbara Bundick</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>904 West Main Street - Salisbury, Maryland 21801</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Green Acres Memorial Park 12/7 Salisbury, MD 21801</u>		20c. LOCATION — City or Town, State <u>Salisbury, MD 21801</u>		22. NAME AND ADDRESS OF FACILITY <u>Fooks Funeral Service</u> <u>917 W. Isabella St. - Salisbury, MD 21801</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Russell A. Fooks</u>				22. NAME AND ADDRESS OF FACILITY <u>Fooks Funeral Service</u> <u>917 W. Isabella St. - Salisbury, MD 21801</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. Perinatal asphyxia</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <u>5d</u>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <u>Suzanne Rindfleisch D.O.</u>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <u>1/29/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Suzanne Rindfleisch D.O.</u>							
31. DATE FILED (Month, Day, Year) <u>FEB 17 1994</u>		32. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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11-25-1918

11-25-1918

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>STEPHEN P. CAVANAUGH</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 20, 1994</b>		3. TIME OF DEATH <b>0815 A M</b>	
4. SOCIAL SECURITY NUMBER <b>362-16-4483</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-8-1913</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>5893 Cumberland Dr.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>	
9c. COUNTY OF DEATH <b>Wicomico</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>Wicomico</b>	
10c. CITY, TOWN OR LOCATION <b>Salisbury</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>5893 Cumberland Dr.</b>	
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II Army</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Glass Cutter &amp; Installer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Glass Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>P. W. Cavanaugh</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Frances Blaul</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary R. Cavanaugh</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10.</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Springhill Memory Gdns. 2/22 Hebron, Md.</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gerald C. Bounds</i>				22. NAME AND ADDRESS OF FACILITY <b>Bounds Funeral Home, Salisbury, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Renal Failure, Acute</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. COLON CANCER</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Suspected prostate cancer</b> <b>Lung cancer, UNO, Agnosed, Suspect wagers</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John A. M.D.</i>				29c. LICENSE NUMBER <b>D39813</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/21/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>W ATKINS MD 1104 Healthways Drive SALIS 21801</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HOWARD CARROLL				2. DATE OF DEATH MONTH 02 DAY 19 YEAR 94		3. TIME OF DEATH 8:00 A M	
4. SOCIAL SECURITY NUMBER 258-03-1782		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	7. DATE OF BIRTH (Month, Day, Year) Sept. 16, 1911	8. BIRTHPLACE (State or Foreign Country) GA		
9a. FACILITY NAME (If not institution, give street and number) P.G. General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cheverley		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION LaPlata		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 41 Old Stage Coach Rd.				10f. ZIP CODE 20646		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Stereotyper		16b. KIND OF BUSINESS/INDUSTRY Newspaper			
17. FATHER'S NAME (First, Middle, Last) John C. Carroll				18. MOTHER'S NAME (First, Middle, Maiden Surname) Beulah E. Howard Carroll			
19a. INFORMANT'S NAME (Type/Print) Ellen Carroll				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Old Stage Coach Rd. LaPlata, MD 20646			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Trinity Mem. Gardens 2-22-94		20c. LOCATION — City or Town, State Waldorf, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE David C. Echols MO0945				22. NAME AND ADDRESS OF FACILITY AREHART-ECHOLS FUNERAL HOME, INC. LaPlata, MD 20646			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Richard J. Feldman MD				29c. LICENSE NUMBER 32261		29d. DATE SIGNED (Month, Day, Year) 2/19/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard J. Feldman MD 4500 ANNAPOLIS RD LARHAN MD							
31. DATE FILED (Month, Day, Year) FEB 23 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. A should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) MATTHEW W. CODY				2. DATE OF DEATH MONTH DAY YEAR FEB 17 1994		3. TIME OF DEATH 1:48 P M	
4. SOCIAL SECURITY NUMBER 215 60 6896		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 41 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 19, 1952	
9a. FACILITY NAME (If not institution, give street and number) 107 WICOMICO ST.				9b. CITY, TOWN OR LOCATION OF DEATH OCEAN CITY		9c. COUNTY OF DEATH WORCESTER	
RESIDENCE OF DECEDENT							
10a. STATE Md		10b. COUNTY Worcester		10c. CITY, TOWN OR LOCATION Ocean City		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 107 Wicomico Street, Apt. A				10f. ZIP CODE 21842		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 2		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bartender		15b. KIND OF BUSINESS/INDUSTRY restaurant			
17. FATHER'S NAME (First, Middle, Last) Roland Cody				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gloria Caulfield			
19a. INFORMANT'S NAME (Type/Print) Gloria Donelson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 West St., Berlin, Md. 21811			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Emmanuel Lutheran Cemetery 2/22/94		20c. LOCATION — City or Town, State Baltimore, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>H. Spivey</i>				22. NAME AND ADDRESS OF FACILITY Burbage Funeral Home, 108 Williams St. Berlin, Md. 21811			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Pneumonia</i> <i>Micronodular Cirrhosis</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Chronic Alcoholism</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Micronodular Cirrhosis, Chronic Alcoholism</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute</i>				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) FEB 18, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21							
31. DATE FILED (Month, Day, Year) FEB 22 1994		32. REGISTRAR'S SIGNATURE <i>John S. Anderson-Randall</i>					

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94 06723

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BARBARA ANNE CUTLER</b>				2. DATE OF DEATH MONTH <b>02</b> - DAY <b>09</b> - YEAR <b>94</b>		3. TIME OF DEATH <b>N/A</b>	
4. SOCIAL SECURITY NUMBER <b>230-50-4186</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>53</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>07-12-40</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>726 GRANTLEY STREET</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>N/A</b>			
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>726 GRANTLEY STREET</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10TH</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>NURSES AIDE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>UNKNOWN Host Taylor</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>IRENE DICKERSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>WINSTON CUTLER</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>726 GRANTLEY ST. BALTIMORE, MD 21229</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		DATE		20c. LOCATION — City or Town, State <b>Witham, Va.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James G. Landis</i>		22. NAME AND ADDRESS OF FACILITY <b>Savage Funeral Home P.O. Box 46 New Church, Va. 23415</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death
		b. <b>STROKES</b> DUE TO (OR AS A CONSEQUENCE OF):					<b>5 years</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. <b>DIABETES MELLITUS</b> DUE TO (OR AS A CONSEQUENCE OF):					<b>Several years</b>
		d. <b>OSTEOMYELITIS</b> DUE TO (OR AS A CONSEQUENCE OF):					<b>6 months</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
<b>ELECTROLYTE IMBALANCE</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>N/A</b>	
<b>ANEMIA</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>N/A</b>		28e. DESCRIBE HOW INJURY OCCURRED <b>N/A</b>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>C. C. Onejeme MD</i>				29c. LICENSE NUMBER <b>D28459</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-12-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>C.C. ONEJEME MD 7127 AMBASSADOR RD, BALTO, MD 21244</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>		32. REGISTRAR'S SIGNATURE <i>John Sander-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760



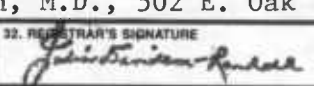
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOSEPH HENRY DAVIS				2. DATE OF DEATH MONTH 2 DAY 15 YEAR 1994		3. TIME OF DEATH 10:00 a.m.	
4. SOCIAL SECURITY NUMBER 220-24-1455		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) SEPT 19 1931	
8. BIRTHPLACE (State or Foreign Country) VIRGINIA							
9a. FACILITY NAME (If not Institution, give street and number) SAND FLAT ROAD				9b. CITY, TOWN OR LOCATION OF DEATH OAKLAND		9c. COUNTY OF DEATH GARRETT	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY GARRETT		10c. CITY, TOWN OR LOCATION OAKLAND		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER SAND FLAT ROAD				10f. ZIP CODE 21550		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ADDICTIONS COUNCILER FOR STATE OF MARYLAND		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) JOSEPH DANIEL DAVIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA M. ASBURY			
19a. INFORMANT'S NAME (Type/Print) JOE DAVIS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1340 BUCKHORN ROAD SYKESVILLE, MARYLAND 21784			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLENDALE CEMETERY FEB 19 1994		OATE		20c. LOCATION — City or Town, State FLINTSTONE MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ventricular Arrhythmia, Acute DUE TO (OR AS A CONSEQUENCE OF): b. Ischemic Heart Disease DUE TO (OR AS A CONSEQUENCE OF): c. Arteriosclerotic Cardio-Vascular Disease DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death Sudden Unknown Unknown
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular Disease							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 05658		29d. DATE SIGNED (Month, Day, Year) February 16, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Herbert H. Leighton, M.D., 502 E. Oak Street, Oakland, Maryland 21550							
31. DATE FILED (Month, Day, Year) FEB 18 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06725

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DONALD W. DAVIS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 20 94</b>				3. TIME OF DEATH <b>1:55</b> P M	
4. SOCIAL SECURITY NUMBER <b>214-07-0908</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>97</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov 8, 1896</b>	
8. BIRTHPLACE (State or Foreign Country) <b>WV</b>				9a. FACILITY NAME (If not institution, give street and number) <b>CUMBERLAND NURSING HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>	
9c. COUNTY OF DEATH <b>ALLEGANY</b>				10a. STATE <b>MD</b>				10b. COUNTY <b>Allegany</b>	
10c. CITY, TOWN OR LOCATION <b>Cumberland</b>				10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>Massachusetts Avenue</b>	
10f. ZIP CODE <b>21502</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW I</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>tire builder</b>				16b. KIND OF BUSINESS/INDUSTRY <b>tire co.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Marcellus Davis</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary O. (NMN)</b>				19a. INFORMANT'S NAME (Type/Print) <b>Mary A Davis</b>	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Cumberland Nursing Home Cumberland MD 21502</b>				20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hillcrest Burial Park 12/23/ Cumberland MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, Maryland 21502</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Coronary artery disease</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>8</b> <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>7</b> <input type="checkbox"/> Nomicide <b>4</b> <input type="checkbox"/> Other	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>033280</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/22/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SUNIL Gupta Johnson Hts. Med. Bld. Cumb. Md. 21502</b>				31. DATE FILED (Month, Day, Year) <b>FEB 24 1994</b>				REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Porgie Annie Pearl Duncan				2. DATE OF DEATH MONTH DAY YEAR February 16, 1994		3. TIME OF DEATH 9:40 PM	
4. SOCIAL SECURITY NUMBER 225-40-2522		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 80 YRS.	7. DATE OF BIRTH (Month, Day, Year) December 30, 1913		8. BIRTHPLACE (State or Foreign Country) VA	
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 400 Robinson Street				10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Labor		16b. KIND OF BUSINESS/INDUSTRY Farm Work			
17. FATHER'S NAME (First, Middle, Last) Charlie Duncan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Susie Kellam			
19a. INFORMANT'S NAME (Type/Print) Annie Harmon				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Robinson Street Salisbury, MD 21801			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Acre Memorial Park 2/21		20c. LOCATION — City or Town, State Salisbury, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Samuel A. Cooke</i>				22. NAME AND ADDRESS OF FACILITY Fooks Funeral Service 917 W. Isabella Street - Salisbury, MD 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CVA. DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Restrictive lung disease</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>C Stegman MD</i>				29c. LICENSE NUMBER D25219		29d. DATE SIGNED (Month, Day, Year) 2-16-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles D. Stegman M.D. PRMC 100 E. Carroll St., Salisbury MD 21801							
31. DATE FILED (Month, Day, Year) FEB 18 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 06727

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARIE LOUISE DONER</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>12</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>3:05PM</b> M	
4. SOCIAL SECURITY NUMBER <b>277-20-9415</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>94</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06-20-1899</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Severna Park, MD</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Severna Park</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>24 Truck House Road</b>				10f. ZIP CODE <b>21146</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMY FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>house wife</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>house wife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>-</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Christopher A. Cox</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Scott</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Diane S. Smith</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>719 Intrepid Way, Davidsonville, MD 21035</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Southern Mem. Gardens 02-18-94</b>		20c. LOCATION — City or Town, State <b>Dunlirk, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>William R. Jones</b>				22. NAME AND ADDRESS OF FACILITY <b>Rausch Funeral Home, P.A., Owings, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEMENZA</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Attending</b>				29c. LICENSE NUMBER <b>D21776</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-12-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SURYA P. MUNNRA MD 202 E. PATARSCO AV. BALTIMORE MD 21225</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 18, 1994</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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94 06728

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Virginia J. Elliott				2. DATE OF DEATH MONTH 2- DAY 20- YEAR 94		3. TIME OF DEATH 03:35a M	
4. SOCIAL SECURITY NUMBER 578-03-5471		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-19-1907	
8. BIRTHPLACE (State or Foreign Country) Md.				9a. FACILITY NAME (If not institution, give street and number) Frostburg Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frostburg	
9c. COUNTY OF DEATH Allegany				10a. STATE Md.			
10b. COUNTY Garrett				10c. CITY, TOWN OR LOCATION Grantsville			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER Route 2, Box 4			
10f. ZIP CODE 21532				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Thomas J. Johnson				16. MOTHER'S NAME (First, Middle, Maiden Surname) Maude Pulliam			
19a. INFORMANT'S NAME (Type/Print) Elizabeth Binkley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 2, Box 4, Grantsville, Md. 21536			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Frostburg Memorial Park		DATE 2/22		20c. LOCATION — City or Town, State Frostburg, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John P. Hahn</i>				22. NAME AND ADDRESS OF FACILITY Durst Funeral Home, Frostburg, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Respiratory failure</i> b. <i>Acute pneumonia</i> c. <i>Conductive heart failure</i> d. <i>Ante-septal myocardial infarction</i> Approximate interval between Onset and Death 14 days 4 days 14 days							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i> <i>Cyst of the ovary</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Nonlethal 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Chang H. Oh</i>				29c. LICENSE NUMBER D24951		29d. DATE SIGNED (Month, Day, Year) Feb. 20, 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Chang H. Oh 48 Tarn Terrace Frostburg, MD 21532							
31. DATE FILED (Month, Day, Year) FEB 22 1994				32. REGISTRAR'S SIGNATURE <i>John P. Hahn</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0620  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Item# 4 Per F.H. Film# G-710 04/11/94 R.M.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROLAND J. ELLIS				2. DATE OF DEATH MONTH DAY YEAR February 14 1994				3. TIME OF DEATH 1404 M	
4. SOCIAL SECURITY 221 22 0097		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
6. DATE OF BIRTH (Month, Day, Year) 12-15-1914				7. BIRTHPLACE (State or Foreign Country) DE.					
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY				9c. COUNTY OF DEATH WICOMICO	
10a. STATE De.		10b. COUNTY Sussex		10c. CITY, TOWN OR LOCATION Delmar				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 800 Grove St.				10f. ZIP CODE 19940				10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 1				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Loan Officer				16b. KIND OF BUSINESS/INDUSTRY BANK	
17. FATHER'S NAME (First, Middle, Last) SETH J. ELLIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) CORA ELLIOTT ELLIS					
19a. INFORMANT'S NAME (Type/Print) NADINE E. ELLIS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Grove St. Delmar, De. 19940					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Stephens Cem. Park				DATE 2-17		20c. LOCATION — City or Town, State Delmar, De.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William M. Roth</i>				22. NAME AND ADDRESS OF FACILITY Short Funeral Home, Inc. P.O. Box 204 Delmar, De. 19940					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Rupture. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): Acute myo. infarction. c. DUE TO (OR AS A CONSEQUENCE OF): Atherosclerotic heart Disease. d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				26b. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Davidson-Randall</i>				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year) 2/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R.H.R. HEATH · 614 Eastern Shore Drive · SALISBURY, MD									
31. DATE FILED (Month, Day, Year) FEB 16 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WALTER ALBERT FRALEY, JR.</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>21</b> YEAR <b>94</b>		3. TIME OF DEATH <b>0235 AM</b>	
4. SOCIAL SECURITY NUMBER <b>214-05-6081</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>05 13 07</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>	
9c. COUNTY OF DEATH <b>ALLEGANY</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ALLEGANY</b>	
10c. CITY, TOWN OR LOCATION <b>CUMBERLAND</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>833 BRADDOCK ROAD</b>	
10f. ZIP CODE <b>21502</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SENIOR VICE-PRESIDENT</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BANKING</b>	
17. FATHER'S NAME (First, Middle, Last) <b>WALTER A. FRALEY, SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>VIOLA LOUISE GERDEMAN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>SANDRA SAWYERS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16415 LAKEWOOD DR.-RAWLINGS, MD 21557</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SS. PETER &amp; PAUL CEM. 223-994</b>		20c. LOCATION — City or Town, State <b>CUMBERLAND, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wendy D. Upchurch</i>				22. NAME AND ADDRESS OF FACILITY <b>GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 215022</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary heart failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Coronary heart disease</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cancer of prostate &amp; metastases Cerebrovascular accident</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Espina MD</i>			
29c. LICENSE NUMBER <b>D03459</b>				29d. DATE SIGNED (Month, Day, Year) <b>2/21/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R. ESPINA MD 902 Seton Dr., Cumberland Md</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 25 1994</b>				32. REGISTRAR'S SIGNATURE <i>John S. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RACHEL Y GOODMAN</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>27</b> YEAR <b>94</b>		3. TIME OF DEATH <b>528 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>None</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>2 1/2</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-13-91</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Howard County General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>		9c. COUNTY OF DEATH <b>Howard</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Columbia</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5378 Five Fingers Way</b>				10f. ZIP CODE <b>21045</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>None</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>None</b>		16b. KIND OF BUSINESS/INDUSTRY <b>None</b>			
17. FATHER'S NAME (First, Middle, Last) <b>David M. Goodman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marielizabeth LeBlond</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joel B. Goodman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>179 Spring St., Saratoga Springs, N.Y. 12866</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Lebanon Cemetery 2/28/1994</b>		20c. LOCATION — City or Town, State <b>Adelphi, Maryland</b>		20d. DATE <b>2/28/1994</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Donald C. Stettin</b>				22. NAME AND ADDRESS OF FACILITY <b>STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL ST., NW, WASHINGTON, DC 20012</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Failure</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Marfan Syndrome</b> <b>S/P Aortic + Mitral Valve Replacement</b>							Approximate Interval Between Onset and Death <b>hours</b> <b>2 yr</b> <b>1 yr</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>scoliosis, high arched palate, arachnoid</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Patrice A. Toy</b>				29c. LICENSE NUMBER <b>D31473</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-28-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PATRICE A. TOYE, MD HOWARD COUNTY GENERAL HOSPITAL COLUMBIA MD</b>							
31. DATE OF DEATH <b>MAR 08 1994</b>				32. REGISTRATION <b>John D. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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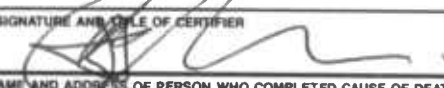

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANNE ARZELLA GREGORY</b>						2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 18, 1994</b>		3. TIME OF DEATH <b>4:50 P.M.</b>		
4. SOCIAL SECURITY NUMBER <b>298-09-9664</b>		5. SEX <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JULY 30, 1909</b>		8. BIRTHPLACE (State or Foreign Country) <b>PENNSYLVANIA</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>OAKLAND</b>			9c. COUNTY OF DEATH <b>GARRETT</b>	
RESIDENCE OF DECEDENT										
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>GARRETT</b>		10c. CITY, TOWN OR LOCATION <b>MT. LAKE PARK</b>				10d. INSIDE CITY LIMITS? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>		
10e. STREET AND NUMBER <b>RT. 135 BOX 808</b>				10f. ZIP CODE <b>21550</b>			10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>COOK</b>			16b. KIND OF BUSINESS/INDUSTRY <b>RESTURANT</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN ROBERT SMITH</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY ZETA GALLAGHER</b>				
19a. INFORMANT'S NAME (Type/Print) <b>W. ERIC WOTRING</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>301 OAKLAND DR. OAKLAND, MARYLAND 21550</b>						
20a. METHOD OF DISPOSITION <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRETT MEMORIAL GARDENS 2/21</b>			20c. LOCATION — City or Town, State <b>OAKLAND, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>MO0167</b>				22. NAME AND ADDRESS OF FACILITY <b>P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD. 21550</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis</b> <b>Due to (or as a consequence of):</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> b. <b>Due to (or as a consequence of):</b> c. <b>Due to (or as a consequence of):</b> d. <b>Due to (or as a consequence of):</b>									Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Empty stomach</b>									24a. WAS AN AUTOPSY PERFORMED? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>			26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> OTHER: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>							
27. MANNER OF DEATH <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <b>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>										
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER <b>D23979</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/21/94</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ROBERT A. GORALSKI, M.D. 311 N. FOURTH ST. OAKLAND, MARYLAND 21550</b>										
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>			32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06733

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Julius Ira Gilpin</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 8, 1994</b>				3. TIME OF DEATH <b>2:50 A M</b>			
4. SOCIAL SECURITY NUMBER <b>214-30-7550</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>59</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-16-1934</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Frostburg Hospital (DOA)</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frostburg</b>				9c. COUNTY OF DEATH <b>Allegany</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Garrett</b>		10c. CITY, TOWN OR LOCATION <b>Grantsville</b>				10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>			
10e. STREET AND NUMBER <b>Rt. 2, Box 82</b>				10f. ZIP CODE <b>21536</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <b>1 NEVER MARRIED 2 MARRIED 3 WIDOWED 4 DIVORCED</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES <b>2-21-57 to 2-20-59</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 11 th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Lift Truck Operator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Fire Brick Plant</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Ira Titus Gilpin</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Clesta Meyers</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Glenna K. Gilpin</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt. 2, Box 82, Grantsville, MD 21536</b>							
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Grantsville Cemetery 2-11</b>				20c. LOCATION — City or Town, State <b>Grantsville, MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>A. Lynn Newman</i>				22. NAME AND ADDRESS OF FACILITY <b>Newman Funeral Homes, P.A. 155 Main St., Grantsville, MD 21536</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>acute myocardial infarction</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <b>atherosclerotic cardiovascular disease</b>  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.  Approximate Interval Between Onset and Death <b>10 minute</b>  <b>1 year</b>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.     								24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>									
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Walter K. Naumann M.D.</i>				29c. LICENSE NUMBER <b>d25759</b>				29d. DATE SIGNED (Month, Day, Year) <b>February 8, 1994</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Walter K. Naumann, M.D., P.O. Box 247, Accident MD 21520</b>											
31. DATE FILED (Month, Day, Year) <b>FEB 16 1994</b>		32. REGISTRAR'S SIGNATURE <i>John R. Anderson</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06734

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES EDWIN GILFORD</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 16, 1994</b>		3. TIME OF DEATH <b>06:40 A M</b>	
4. SOCIAL SECURITY NUMBER <b>214 05 5821</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUG 8 1919</b>	
8. BIRTHPLACE (State or Foreign Country) <b>PENNA.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>	
9c. COUNTY OF DEATH <b>ALLEGANY</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ALLEGANY</b>	
10c. CITY, TOWN OR LOCATION <b>CUMBERLAND</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1115 FREDERICK STREET</b>	
10f. ZIP CODE <b>21502</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>KELLY SPRINGFIELD TIRE CO</b>		16b. KIND OF BUSINESS/INDUSTRY <b>FOREMAN/ TIRE CO.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>PAUL WILLIAM GILFORD</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CLARA SARAH MATTHEWS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FRANCES LEE GILFORD</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1115 FREDERICK STREET CUMBERLAND MARYLAND 21502</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SUNSET MAUSOLEUM FEB 19 1994</b>		20c. LOCATION — City or Town, State <b>CUMBERLAND MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY <b>MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's Disease, Coronary artery disease</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas Evan Chappell MD</i>				29c. LICENSE NUMBER <b>MD 35135</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/17/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Thomas Evan Chappell MD 912 seton Dr. Cumberland MD</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 18 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 06735

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARJORIE PATRICIA GUMPHREY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 17, 1994</b>		3. TIME OF DEATH <b>08:15 AM</b>	
4. SOCIAL SECURITY NUMBER <b>217 28 0357</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>60</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>FEB 26 1933</b>	
8. BIRTHPLACE (State or Foreign Country) <b>W. Va.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>	
9c. COUNTY OF DEATH <b>ALLEGANY</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ALLEGANY</b>	
10c. CITY, TOWN OR LOCATION <b>CUMBERLAND</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>822 GREENE STREET</b>	
10f. ZIP CODE <b>21502</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HOUSE KEEPER</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSE KEEPER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOUSE KEEPER</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JOSEPH L. CARRICO</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARJORIE RENSHAW</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ROBERT C. GUMPHREY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>822 GREENE STREET CUMBERLAND MARYLAND 21502</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ROCKY GAP VET CEMETERY FEB 19 1994 FLINTSTONE MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY <b>MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): <b>End stage COPD</b> c. DUE TO (OR AS A CONSEQUENCE OF): <b>Cigarette Smoking</b> d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jesus Tan</i>				29c. LICENSE NUMBER <b>D21244</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/17/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Jesus Tan, M.D. Frostburg, MD 21532</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 18 1994</b>				32. REGISTRAR'S SIGNATURE <i>John T. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06736

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FRANCIS EARL GRAY</b>				2. DATE OF DEATH MONTH <b>FEBRUARY</b> DAY <b>19</b> YEAR <b>94</b>		3. TIME OF DEATH <b>0842 PM</b>	
4. SOCIAL SECURITY NUMBER <b>215-16-4881</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Mar 16, 1920</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND, MD</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1 Baltimore Street</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>retired</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>retired</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Market</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Earl M. Gray</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bertha M. Green</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Patricia E Wigger</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>122 Blackiston Avenue Cumberland MD 21502</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Mary's Cemetery</b>		20c. LOCATION — City or Town, State <b>2/23/ Cumberland MD</b>		22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, Maryland 21502</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, Maryland 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. <b>VENTRICULAR FIBRILLATION</b> DUE TO (OR AS A CONSEQUENCE OF):							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST f. <b>CORONARY HEART DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):							
g. <b>RECURRENT ASPIRATION PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF):							
h. <b>RECURRENT RESPIRATORY FAILURE.</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Shah</i>				29c. LICENSE NUMBER <b>623334</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/19/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. SHAH P.O. BOX 161 PINTO, MD 21556</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>				32. REGISTRAR'S SIGNATURE <i>James F. Scarpelli</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0060

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten signature and date: 10/10/19

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELIAS GERSTNER</b>				2. DATE OF DEATH MONTH <b>FEB</b> DAY <b>16</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>1:25 A M</b>	
4. SOCIAL SECURITY NUMBER <b>219-38-8264</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-17-1914</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>HARBOR HOSPITAL</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		8c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Calvert</b>		10c. CITY, TOWN OR LOCATION <b>Huntingtown</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1380 Cox Road</b>				10f. ZIP CODE <b>20639</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mechanic</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Maryland Cup Corp</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Peter Gerstner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Barbara Meyer</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Elfriede T. Weedon</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1400 S. Carey Street Baltimore, MD 21230</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>So. Memorial Gardens 2-18-94</b>		20c. LOCATION — City or Town, State <b>Dunkirk, Maryland</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Rausch Funeral Home P.A. Owings, MD 20736</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>Inquiry</b>
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB. 16, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 18, 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SYLVIA CATHERINE HUNTER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 7, 1994</b>		3. TIME OF DEATH <b>8:25 P M</b>	
4. SOCIAL SECURITY NUMBER <b>215-26-6720</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-5-1929</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital &amp; Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Garrett</b>		10c. CITY, TOWN OR LOCATION <b>Frostburg (Rural Garrett Co.)</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Route 2, Box 621</b>				10f. ZIP CODE <b>21532</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>1 yr</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Clifford Caton</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Verna McKenzie</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Lester Hunter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt. 2, Box 621, Frostburg, MD 21532</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Finzel Cemetery 2-10</b>		20c. LOCATION — City or Town, State <b>Finzel, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Newman Funeral Homes, P.A. 155 Main St., Grantsville, MD 21536</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>RESPIRATORY FAILURE</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CNS Vasculitis</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Renal failure, Vasculitis, C.A.D.</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal failure, Vasculitis, C.A.D.</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE NOW INJURY OCCURRED			
28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28c. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>N.A. Ranjithan</i>				29c. LICENSE NUMBER <b>D 19318</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/8/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>N. Ranjithan M.D. 517 Oldtown Road Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 16 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit without be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Brenda Yvonne Hawkins				2. DATE OF DEATH MONTH 2 DAY 10 YEAR 94		3. TIME OF DEATH 2:35 P M	
4. SOCIAL SECURITY NUMBER 220-64-4501		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 39 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2-21-1954	
9a. FACILITY NAME (If not institution, give street and number) Frostburg Hospital, Inc				9b. CITY, TOWN OR LOCATION OF DEATH Frostburg		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Grantsville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Rt. 1, Box 179, Dorsey Hotel Rd.				10f. ZIP CODE 21536		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 8+) 4 yrs.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nursing Assistant		16b. KIND OF BUSINESS/INDUSTRY Nursing Home			
17. FATHER'S NAME (First, Middle, Last) James Blake Hawkins				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Anderson			
19a. INFORMANT'S NAME (Type/Print) Dorothy A. Hawkins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2518 Edmondson Ave., Baltimore, MD 21223			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cherry Glade Cemetery 2-13 Accident, MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>A. Lynn Newman</i>				22. NAME AND ADDRESS OF FACILITY Newman Funeral Homes, P.A. 155 Main St., Grantsville, MD 21536			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>RESPIRATORY FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>PULMONARY METASTASES</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>CARCINOMA of Right Breast</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Bone metastases</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>S. Changin D</i>				29c. LICENSE NUMBER <i>D25638</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/11/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>SATURNINA CHANG, M.D. FROSTBURG PLAZA FROSTBURG, MD 21532</i>							
31. DATE FILED (Month, Day, Year) <i>FEB 16 1994</i>				32. REGISTRAR'S SIGNATURE <i>S. Changin D</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

STANDARD FORM NO. 64

OFFICE OF THE SECRETARY OF AGRICULTURE

*[Faint, mostly illegible text and markings on lined paper, possibly bleed-through from the reverse side.]*

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FRENCH JUNIOR HINKLE</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>09</b> YEAR <b>94</b>		3. TIME OF DEATH <b>03:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>234 26 9771</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 27, 1923</b>	
8. BIRTHPLACE (State or Foreign Country) <b>WV</b>		9a. FACILITY NAME (If not Institution, give street and number) <b>SACRED HEART HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>WV</b>		10b. COUNTY <b>Mineral</b>		10c. CITY, TOWN OR LOCATION <b>Keyser</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Rt 4, Box 241</b>				10f. ZIP CODE <b>26726</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Equipment Operator</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Paper Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Hobart G. Hinkle</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margie Mallow</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Imojean M. Phares</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1038 WR Lane, Lot 5, Burlington, NC 27217</b>			
20. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Kline Cemetery 2/16/94</b>		20c. LOCATION — City or Town, State <b>Kline, WV</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Handwritten Signature</i>				22. NAME AND ADDRESS OF FACILITY <b>Markwood McKenzie Funeral Home 111 S. Mineral St., Keyser, WV 26726</b>			
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Small bowel obstruction &amp; surgical complications</i> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Metastatic CRM CA</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>N. McCullough</i>				29c. LICENSE NUMBER <b>D 44712</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/16/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>N. McCullough 902 Seton Drive Suite 303 Cumberland Md 21044</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 17 1994</b>				32. REGISTRAR'S SIGNATURE <i>John Benson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06741

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JACK R. HUSSON</b>				2. DATE OF DEATH MONTH <b>February</b> DAY <b>19</b> , YEAR <b>1994</b>		3. TIME OF DEATH <b>9:46 A</b> M	
4. SOCIAL SECURITY NUMBER <b>187-24-2309</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan 12, 1932</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital &amp; Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>722 Hilltop Drive</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Korean</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>advertising/sales</b>		16b. KIND OF BUSINESS/INDUSTRY <b>newspaper</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John W. Husson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ada Snyder</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Betty J. Husson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>722 Hilltop Drive Cumberland MD 21502</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rocky Gap Veterans Cemetery 2/22/</b>		20c. LOCATION — City or Town, State <b>Flintstone MD</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Scarpelli</b>	
22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, Maryland 21502</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiomyopathy</b> <b>Atherosclerosis</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. Guy Fiscus</b>		29c. LICENSE NUMBER <b>D12779</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/20/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Guy Fiscus Memorial Hospital Medical Building Cumberland, MD. 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>				32. REGISTRAR'S SIGNATURE <b>John D. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PAUL HALL</b>				2. DATE OF DEATH MONTH <b>FEBRUARY</b> DAY <b>22</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>1153PM</b> M	
4. SOCIAL SECURITY NUMBER <b>217-10-1668</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>03-01-1916</b>	
8. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		10. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Oldtown</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>P.O. Box 57- Gravel Bar Road</b>				10f. ZIP CODE <b>21555</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>none</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>none</b>		16b. KIND OF BUSINESS/INDUSTRY <b>n/a</b>			
17. FATHER'S NAME (First, Middle, Last) <b>nfn</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>nmn</b>			
19a. INFORMANT'S NAME (Type/Print) <b>American Trust Bank</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>81 Baltimore Street, Cumberland, MD 21502</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rocky Gap Veterans Cem. 02-25</b>		20c. LOCATION — City or Town, State <b>Flintstone, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DUA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. Robustiano J. Barrera</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>2-22-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. ROBUSTIANO J. BARRERA 500 MEMORIAL AVE., CUMBERLAND, MD 21502</b>							
31. DATE FILED WITH REGISTRY <b>FEB 24 1994</b>				32. REGISTRAR'S SIGNATURE <b>John D. Anderson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without delay after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 06743

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>William Earl Howeth</b> <b>William E. Howeth</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>11</b> YEAR <b>94</b>		3. TIME OF DEATH <b>1:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>215-05-5411</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>72</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>July 28, 1921</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Wicomico Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>		9c. COUNTY OF DEATH <b>Wicomico</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Salisbury</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1407 Emerson Ave.</b>				10f. ZIP CODE <b>21801</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Carpenter</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Boat Building</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Earl Willard Howeth</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lena (unk) Powell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sarah Howeth</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1407 Emerson Ave., Salisbury, MD 21801</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Springhill Memory Gardens</b>		20c. DATE <b>2/15</b>		20d. LOCATION — City or Town, State <b>Hebron, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Holloway Funeral Home</b> <b>501 Snow Hill Rd., Salisbury, MD 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Broncho Pneumonia</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div> <b>Due to (or as a consequence of):</b>  <b>Copilot</b>  <b>Mental Incompetent</b>  <b>Hypertension Disease</b> </div> <div> <b>Approximate Interval Between Onset and Death</b>  <b>13 days</b>  <b>1?</b>  <b>1 year</b>  <b>70y</b> </div> </div>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>7/6 Tube —</b> <b>diffuse Arteriosclerosis</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D2026</b>		29d. DATE SIGNED (Month, Day, Year) <b>2 12 94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>F.G. Arthes, MD 1622 A Ocean Pines, Berlin, Md. 21811</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 15 1994</b>				32. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

THE AMERICAN PEOPLE

BRITISH



JONES, EDNA P.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Edna P. Jones</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 22 1994</b>				3. TIME OF DEATH HOURS MINUTES AM/PM <b>7:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213-05-0006</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3-17-1906</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Salisbury Nursing &amp; Rehab Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury, Md. 21801</b>				9c. COUNTY OF DEATH <b>Wicomico</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Somerset</b>		10c. CITY, TOWN OR LOCATION <b>Chance</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>c/o P.O. Toddville Rd. 10771</b>				10f. ZIP CODE <b>21816</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>SEA Food</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Isiah Powell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Campise Powell</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Ralph Jones</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10771 Toddville Rd. Chance Md, 21816</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Charles Cem 2-28-94</b>		20c. LOCATION — City or Town, State <b>Chance Md.</b>		20d. DATE <b>2-28-94</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Anthony E. Ward F.D.</b>				22. NAME AND ADDRESS OF FACILITY <b>30639 Hampden Ave. Princess Anne Md 21853</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Diabetes</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Diabetes</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Diabetes</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>CVA</b> DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death <b>5</b> <b>10</b> <b>4</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>							
		29c. LICENSE NUMBER <b>D-29349</b>				29d. DATE SIGNED (Month, Day, Year) <b>2/22/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>WILLIAM ROBINS, M.D. 1104 HEALTHWAY DRIVE, SALISBURY, MD. 21801</b>									
31. DATE FILED (Month, Day, Year) <b>FEB 24 '94</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 through 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

2. The second part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

3. The third part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

4. The fourth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

5. The fifth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

6. The sixth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

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11. The eleventh part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

12. The twelfth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

94 06745

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM DAVIDSON JOBSON</b>						2. DATE OF DEATH MONTH DAY YEAR <b>February 17 1994</b>			3. TIME OF DEATH HOURS MINUTES <b>6:55 p.m.</b>		
4. SOCIAL SECURITY NUMBER <b>220-10-2519</b>		5. SEX <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>		6. AGE (In yrs. last birthday) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 30 1919</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Frostburg Village Nursing Home</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Frostburg</b>			9c. COUNTY OF DEATH <b>Allegany</b>		
RESIDENCE OF DECEDENT											
10a. STATE <b>Md</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Barton</b>				10d. INSIDE CITY LIMITS? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>			
10e. STREET AND NUMBER <b>High St.</b>						10f. ZIP CODE <b>21521</b>			10g. CITIZEN OF WHAT COUNTRY? <b>US</b>		
11. MARITAL STATUS <b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:</b>				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) Unknown</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Westvaco Employee</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Paper Manufacturing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William D. Jobson</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ester Langham</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Edith Phillips</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Barton, Md. 21521</b>					
20a. METHOD OF DISPOSITION <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Laurel Hill Cemetery 2-20-94</b>				20c. LOCATION — City or Town, State <b>Barton, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Wayne Boal</b>						22. NAME AND ADDRESS OF FACILITY <b>Boal Funeral Service 111 Church St. Westernport, Md. 21562</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											
a. <b>Cardiac arrest</b> DUE TO (OR AS A CONSEQUENCE OF):											
b. <b>Constrictive heart failure</b> DUE TO (OR AS A CONSEQUENCE OF):											
c. <b>Coronary artery disease</b> DUE TO (OR AS A CONSEQUENCE OF):											
d. <b>Chronic obstructive lung disease</b> DUE TO (OR AS A CONSEQUENCE OF):											
e. <b>Chronic obstructive lung disease</b> DUE TO (OR AS A CONSEQUENCE OF):											
f. <b>Chronic obstructive lung disease</b> DUE TO (OR AS A CONSEQUENCE OF):											
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h. <b>Chronic obstructive lung disease</b> DUE TO (OR AS A CONSEQUENCE OF):											
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Velma Delmita Nutter Johnson				2. DATE OF DEATH MONTH 01 DAY 22 YEAR 94		3. TIME OF DEATH 330 P M	
4. SOCIAL SECURITY NUMBER 219-20-5359		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) September 6, 1900	
9a. FACILITY NAME (If not institution, give street and number) (HOME) 30566 South Street				9b. CITY, TOWN OR LOCATION OF DEATH Princess Anne		9c. COUNTY OF DEATH Somerset	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Princess Anne		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 30566 South Street				10f. ZIP CODE 21853		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Unknown		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		15b. KIND OF BUSINESS/INDUSTRY Domestic			
17. FATHER'S NAME (First, Middle, Last) John H. Nutter				16. MOTHER'S NAME (First, Middle, Maiden Surname) Anne King			
19a. INFORMANT'S NAME (Type/Print) Elizabeth Richards				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30566 South Street - Princess Anne, MD 21853			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Full Cemetery		DATE 1/29		20c. LOCATION — City or Town, State Pocomoke City, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Russell A. Fooks</i>				22. NAME AND ADDRESS OF FACILITY Fooks Funeral Service 917 W. Isabella Street - Salisbury, MD 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Arteriosclerotic Heart Disease</i>					Approximate Interval Between Onset and Death 2 yrs
		b. <i>Coronary Arteriosclerosis</i>					2 yrs
		c. <i>Generalized Arteriosclerosis</i>					5 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Congestive Heart Failure</i> <i>Stasis Edema and ulcers, legs</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gregorio M. Bellosso M.D.</i>				29c. LICENSE NUMBER D 29505		29d. DATE SIGNED (Month, Day, Year) 2-3-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREGORIO M. BELLOSO, M.D. 421 BEECHWOOD PL., CRISFIELD, MD 21817							
31. DATE FILED (Month, Day, Year) FEB 17 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Johnny</b>				2. DATE OF DEATH MONTH <b>February</b> DAY <b>9</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>2230 P M</b>	
4. SOCIAL SECURITY NUMBER <b>425-74-0799</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <b>2</b> <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>56</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 1, 1941</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		8c. COUNTY OF DEATH <b>WICOMICO</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Salisbury</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>114 Parsons Street Apt. 1</b>				10f. ZIP CODE <b>21801</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Viet-Nam</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b> Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Labor</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Roofing</b>			
16. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Unknown</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Roofing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Ezell Jones</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lillie Mae Jones</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Virginia Jones</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>114 Parsons Street Apt. 1 Salisbury, MD 21801</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. James Amchurch 2/22 Westover, MD</b>		20c. LOCATION — City or Town, State <b>Westover, MD</b>		20d. LOCATION — City or Town, State <b>Westover, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Fussell B. Fooks</i>				22. NAME AND ADDRESS OF FACILITY <b>Fooks Funeral Service 917 W. Isabella St. Salisbury, MD 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Ca Lung</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>6 M</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>							24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) <b>HOSPITAL:</b> <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA <b>OTHER:</b> <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>		27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>7</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>WR Schmitt</i>				29c. LICENSE NUMBER <b>MD-D17596</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-14-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>WR Schmitt MD 300 N. Ducl Hwy, LAUREL DE 19956</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 18 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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94 06748

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Beulah Estelle Shipley Johnson</b>				2. DATE OF DEATH MONTH <b>February</b> DAY <b>18</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>1:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>577-26-8017</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>97</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>December 19, 1896 Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>St. Mary's Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Leonardtwn</b>		9c. COUNTY OF DEATH <b>St. Mary's</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>St. Mary's</b>		10c. CITY, TOWN OR LOCATION <b>Mechanicsville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>76 Beach Drive</b>				10f. ZIP CODE <b>20659</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Book Binder</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Publishing Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Walter L. Shipley</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ada M. Lusby</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Doris J. Hodges</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>76 Beach Drive, Mechanicsville, Maryland 20659</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery 02-22-1994</b>		20c. LOCATION — City or Town, State <b>Suitland, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Mark G. Brohawn M00053</b>				22. NAME AND ADDRESS OF FACILITY <b>THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RENAL FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Robert J. Bauer, M.D.</b>				29c. LICENSE NUMBER <b>D14168</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/18/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Robert J. Bauer, M.D., 993 Old Rt. #5, Mechanicsville, Maryland 20659</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Marian Humphreys Joyner</b>				2. DATE OF DEATH MONTH <b>2/</b> DAY <b>19/</b> YEAR <b>94</b>		3. TIME OF DEATH <b>5:45 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>218-40-5954</b>		5. SEX <b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>81</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>3/ 6/12</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>own home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Snow Hill, Md.</b>		9c. COUNTY OF DEATH <b>Worcester</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>Snow Hill</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>106 E. Market Street</b>				10f. ZIP CODE <b>21863</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>School Teacher</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Education</b>			
17. FATHER'S NAME (First, Middle, Last) <b>A.C. Humphreys</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Virgie Humphreys</b>			
19a. INFORMANT'S NAME (Type/Print) <b>N. Paul Joyner</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>106 E. Market Street, Snow Hill, Md. 21863</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Whatcoat Methodist Cemetery 2/94</b>		20c. LOCATION — City or Town, State <b>Snow Hill, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patricia L. Dennis</i>				22. NAME AND ADDRESS OF FACILITY <b>Dennis Funeral Home, Snow Hill, Md. 21863</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PULMONARY EMPHYSEMA WITH ASTHMA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.							Approximate Interval Between Onset and Death <b>1 YEARS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RECENT SURGICAL TREATMENT → ADULT A NEPHROSY (ABDOMINAL)</b> <b>EMPHYSEMA AND INFLAMMATION</b>							24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>6</b> <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert C. LaMar, M.D.</i>				29c. LICENSE NUMBER <b>D-05865-</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB 19, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ROBERT C. LAMAR, MD. 104 N. BAY ST. SNOW HILL, MD. 21863</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>		32. REGISTRAR'S SIGNATURE <i>John D. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MICHAEL ALBERT KALBAUGH</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB. 15, 1994</b>		3. TIME OF DEATH <b>7:40 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214-07-4096</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JUL 17, 1904</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ALLEGANY</b>		10c. CITY, TOWN OR LOCATION <b>LAVALE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8 DEAL AVENUE</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>PIPEFITTER</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CELANESE</b>		16b. KING OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE EDWARD KALBAUGH</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FLORA UNKNOWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CHARLES HILL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 92, CUMBERLAND, MD 21502</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SILBAUGH CREMATORY 2/17</b>		20c. LOCATION — City or Town, State <b>UNIONTOWN, PA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Douglas A. Hafer</i>		22. NAME AND ADDRESS OF FACILITY <b>HAFER CHAPEL OF THE HILLS MORTUARY 1302 NAT'L HWY. LAVALE, MD 21502</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>cardiac dysrhythmia</i> a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): <i>coronary artery disease</i> c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>severe ulcerative proctitis</i> <i>Organic brain syndrome</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D21244</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/17/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JESUS TAN M.D. FROSTBURG PLAZA, FROSTBURG, MD 21532</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 18 1994</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KATHERINE ELIZABETH KLINE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 21, 1994</b>		3. TIME OF DEATH <b>3:50 A M</b>	
4. SOCIAL SECURITY NUMBER <b>217-10-6004</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec 18, 1917</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Route 3 Box 129</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. FATHER'S STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>former employee</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>former employee</b>		16b. KIND OF BUSINESS/INDUSTRY <b>textile</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Walter Rank</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jenny E. (Love)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Robert C Babst</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>303 Harbor Ridge Drive Goodview VA 24095</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hillcrest Burial Park 2/24/</b>		20c. LOCATION — City or Town, State <b>Cumberland MD</b>		20d. DATE <b>2/24/</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jane F Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, Maryland 21502</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerosis</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <b>Sepsis</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>CVA (Stroke)</b> c. DUE TO (OR AS A CONSEQUENCE OF): <b>Renal failure</b> d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dr</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Vik Poonai</b>				29c. LICENSE NUMBER <b>D 36766</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/21/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Vik Poonai PO Box 338, Cumberland, MD 21501</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>				32. REGISTRAR'S SIGNATURE <b>Jane S. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transmit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>VIRGINIA ELIZABETH KELLY</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>21</b> YEAR <b>94</b>		3. TIME OF DEATH <b>8:57 P M</b>	
4. SOCIAL SECURITY NUMBER <b>217-10-6883</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12 28 19</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>LaVale</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3 Glenview Drive</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>X</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b> Elementary/Secondary (0-12)      College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>own home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Harry E. Minnicks, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Pearl V. (Wade)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William J. Kelly</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9 Glenview Drive LaVale MD 21502</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> 2 Cremation <input type="checkbox"/> 3 Removal from State <input type="checkbox"/> 4 Donation <input type="checkbox"/> 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sunset Memorial Park 2/24/</b>		20c. LOCATION — City or Town, State <b>Cumberland MD</b>		22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, Maryland 21502</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, Maryland 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis Syndrome</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Bladder-Colon fistula</b> <b>probable diverticulitis</b>							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Pulmonary Disease</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> 5 Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> 6 Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> 7 Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wayne C. Spiggle</i>				29c. LICENSE NUMBER <b>D11443</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-23-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <b>DR. WAYNE SPIGGLE, M.D., 912 SETON DRIVE, CUMBERLAND, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020  
DIVISION OF VITAL RECORDS, P.O. BOX 68760,  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DORCIL WESLEY KLINE</b>				2. DATE OF DEATH MONTH <b>February</b> DAY <b>23</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>03:05 A</b> <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>705-10-4969</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 7 1913</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital &amp; Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ALLEGANY</b>		10c. CITY, TOWN OR LOCATION <b>CUMBERLAND</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>RFD# 2 BOX# 805</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (14 or 5+) <b>9</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>WESTERN MARYLAND RAILROAD</b>		15b. KIND OF BUSINESS/INDUSTRY <b>BRAKEMAN &amp; MACHINIST</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM KLINE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>AMANDA SMITH</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DORCIL W. KLINE JR.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RFD#3 BOX#638 BEDFORD PENNA. 15522</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sunset memorial cemetery FEB 26 1994 CUMBERLAND MARYLAND</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY <b>MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Acute Myocardial Infarction</i>					
		DUE TO (OR AS A CONSEQUENCE OF):					
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Gupta</i>				29c. LICENSE NUMBER <b>D33280</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/23/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Gupta Johnson Heights Medical Building Cumberland, MD. 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 24 1994</b>				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-002

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06754

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KYLE ACE KASH</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 18, 1994</b>		3. TIME OF DEATH <b>2:23 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>220-12-1178</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-31-1926</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD.</b>		10b. COUNTY <b>WICOMICO</b>		10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>P.O. BOX 2791</b>				10f. ZIP CODE <b>21801</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>OPTICAL</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>OPTICAL</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OPTICAL COMPANY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>CHARLES C. SIMPSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MIRIAM B. TYNDALL</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MEGAN KASH</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 2791 SALISBURY, MD. 21801</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PARSONS CEMETERY</b>		20c. LOCATION — City or Town, State <b>2-22 SALISBURY, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald C. Bounds</i>				22. NAME AND ADDRESS OF FACILITY <b>BOUNDS FUNERAL HOME, SALISBURY, MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>SEPSIS</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>POST OPERATIVE INFECTION</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>WHIPPLE PANCREATIC RESECTION</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <b>METASTATIC CARCINOMA OF PANCREAS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Davidson-Randall</i>				29c. LICENSE NUMBER <b>241567</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/19/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NICHOLAS DUDAS 145 E. CARROLL ST SALISBURY MD 21801</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2

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U.S. DEPT. OF JUSTICE

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U.S. DEPT. OF JUSTICE

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DOROTHY O KING				2. DATE OF DEATH 02 MONTH 14 DAY 94 YEAR		3. TIME OF DEATH 10:15 AM	
4. SOCIAL SECURITY NUMBER 214-32-8141		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 15, 1916	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE	
9c. COUNTY OF DEATH A.A. COUNTY				10a. STATE Maryland		10b. COUNTY Calvert	
10c. CITY, TOWN OR LOCATION Prince Frederick				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 420 W. Dares Beach Rd.	
10f. ZIP CODE 20678				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (14 or 5+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) William Gray				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Butler			
19a. INFORMANT'S NAME (Type/Print) Janice Dawkins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3105 Oakley Ave. Baltimore, MD 21215			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Brooks Church Cem. 02/21/94		20c. LOCATION — City or Town, State St. Leonard, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Spencer E. Sewell				22. NAME AND ADDRESS OF FACILITY Sewell Funeral Home 1451 Dares Beach Rd. Prince Fred., MD 20678			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of liver DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ① COPD ③ NO CPR ② MI/DM							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER J. M. D.			
29c. LICENSE NUMBER D-19528				29d. DATE SIGNED (Month, Day, Year) 2/16/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ELMO M. GAYOSO, M.D./273-F PENINSUL FARM ROAD/ARNOLD, MARYLAND 21012							
31. DATE FILED (Month, Day, Year) FEB 18, 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY VIRGINIA KISNER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB. 21 1994</b>		3. TIME OF DEATH <b>5:25 P M</b>		
4. SOCIAL SECURITY NUMBER <b>232-96-2782</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>93 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>AUG. 28, 1900</b>		
8. FACILITY NAME (If not institution, give street and number) <b>WILSON HEALTH CARE CENTER/ASBURY HOME</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>GAITHERSBURG</b>		10. COUNTY OF DEATH <b>MONTGOMERY</b>		
10a. STATE <b>MD</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>GAITHERSBURG</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>211 RUSSELL AVENUE</b>				10f. ZIP CODE <b>20877</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>HOME</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOME</b>				
17. FATHER'S NAME (First, Middle, Last) <b>HARRY HAMILTON SIMPSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA REBECCA BYERS</b>				
19a. INFORMANT'S NAME (Type/Print) <b>CALVIN L. KISNER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>506 CARA COURT, MARTINSBURG, WV 25401</b>				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CENTRAL CHAPEL CEMETERY</b>		DATE <b>2/24</b>		20c. LOCATION — City or Town, State <b>RFD, HEDGESVILLE, WV</b>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles M. Brown</i>				22. NAME AND ADDRESS OF FACILITY <b>BROWN FUNERAL HOME, 327 W. KING ST. PO BOX 821, MARTINSBURG, WV 25401</b>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>cardiac arrest</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>coronary artery disease</i>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>diabetes hypotension</i>							Approximate interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Goldstein MD</i>				29c. LICENSE NUMBER <b>D03518</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/24/94</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Elliot R. Goldstein, M.D.; 9410 Old Georgetown Rd, Bethesda, Md. 20814</b>								
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <i>Johanna Davidson-Henderson</i>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ITEMS: 23 PART II, PER MEO FILM G-712 6/8/94 t.t.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Genevieve D. King</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>16</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>1:20 a m</b>	
4. SOCIAL SECURITY NUMBER <b>215-38-0986</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>04/01/1904</b>	
8. BIRTHPLACE (State or Foreign Country) <b>North Dakota</b>		9a. FACILITY NAME (If not institution, give street and number) <b>30370 Charles Barnes Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Westover</b>		9c. COUNTY OF DEATH <b>Somerset</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Somerset</b>		10c. CITY, TOWN OR LOCATION <b>Westover</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>30370 Charles Barnes Road</b>				10f. ZIP CODE <b>21871</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>3</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Registered Nurse</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Menno B. Detwiler</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sadie Frances Sharp</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Marolyn Minnich</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>30376 Charles Barnes Rd., Westover, Md. 21871</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holly Grove Mennonite Cemetery</b>		20c. DATE <b>2/19</b>		20d. LOCATION — City or Town, State <b>Westover, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott S. Melson</i>				22. NAME AND ADDRESS OF FACILITY <b>Melson Funeral Home</b> <b>PO BOX 64, Pocomoke City, Md. 21851</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Endometrial Cancer</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>7x hyp (PATHOLOGIC)</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul R. Illing</i>				29c. LICENSE NUMBER <b>024872</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/17/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>560 Riverside Dr A204 Salisbury md</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julius Sanders-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lulu M. Kelly</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>19</b> YEAR <b>994</b>		3. TIME OF DEATH <b>1:50 pm</b>	
4. SOCIAL SECURITY NUMBER <b>225-40-4854</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>04-20-1906</b>	
8. BIRTHPLACE (State or Foreign Country) <b>ATLANTIC</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Deer's Head Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>	
9c. COUNTY OF DEATH <b>Wicomico</b>				10a. STATE <b>VA</b>		10b. COUNTY <b>ACCOMACK</b>	
10c. CITY, TOWN OR LOCATION <b>ATLANTIC</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER	
10f. ZIP CODE <b>23303</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10THGRADE</b> College (1-4 or 5+) <b>PHARMACY</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ATLANTIC PHARMACY</b>				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>LAWRANCE THORTON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LULA BUNTING</b>			
19a. INFORMANT'S NAME (Type/Print) <b>TERESA MCCREADY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>WALLOPS ISLAND, VA 23337</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>JOHN W. TAYLORS CEMETERY 2-22-94</b>			
20c. LOCATION — City or Town, State <b>TEMPERANCEVILLE</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James N. Fay</i>			
22. NAME AND ADDRESS OF FACILITY <b>FOX FUNERAL HOME TEMPERANCEVILLE, VA 23442</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart failure</b> Approximate Interval Between Onset and Death <b>30 mins</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Cancer of lung - left apex</b> <b>Hypertension</b> <b>Diabetes Mellitus</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Rectal hemorrhoids S.P. fracture, left hip with ORIF, UTI, Herpes zoster of face - Monilial dermatitis</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year) <b>FEB. 10, 1994</b>				28b. TIME OF INJURY <b>8:30 P M</b>			
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED <b>SUBJECT FELL</b>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>NURSING HOME</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>HARTLEY-HALL NH POCOMOKE CITY, MD.</b>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>M. Shrestha MD</b>			
29c. LICENSE NUMBER <b>D16278</b>				29d. DATE SIGNED (Month, Day, Year) <b>2-19-94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. M. Shrestha; P.O. Box 2018; Salisbury, Md. 21802</b>				31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>			
32. REGISTRAR'S SIGNATURE <i>John Benson-Randall</i>				5			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Carl B. King</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb 14, 1994</b>		3. TIME OF DEATH <b>1:15 P. M.</b>	
4. SOCIAL SECURITY NUMBER <b>238-03-3366</b>		5. SEX <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 21, 1909</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Roxboro, N.C.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Harrison House Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Snow Hill, Md.</b>	
9c. COUNTY OF DEATH <b>Worcester</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>Worcester</b>	
10c. CITY, TOWN OR LOCATION <b>Snow Hill, Md.</b>				10d. INSIDE CITY LIMITS? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>		10e. ZIP CODE <b>21863</b>	
10f. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b> IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>College</b>	
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>electrician</b>				17. KIND OF BUSINESS/INDUSTRY <b>Contractor Self-Employed Electrical</b>		18. FATHER'S NAME (First, Middle, Last) <b>John Wesley King</b>	
19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mollie Bet Carr King</b>				20. INFORMANT'S NAME (Type/Print) <b>John King</b>		21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>115 W. Martin Street, Snow Hill, Md. 21863</b>	
22. METHOD OF DISPOSITION <b>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>				23. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Wilcomico Memorial Park 2/94</b>		24. LOCATION — City or Town, State <b>Salisbury, Md.</b>	
25. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patricia L. Dennis</i>				26. NAME AND ADDRESS OF FACILITY <b>Dennis Funeral Home, Snow Hill, Md. 21863</b>		27. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ISCHEMIC CARDIOMYOPATHY</b> DUE TO (OR AS A CONSEQUENCE OF): <b>ARTERIO SCLEROTIC HEART DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>GENERALIZED ATHEROSCLEROSIS</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
28. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> <b>RENAL INSUFFICIENCY</b> <b>HYPOTHYROIDISM. CHRONIC ATRIAL FIBRILLATION</b>				29. WAS AN AUTOPSY PERFORMED? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>		30. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>	
31. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>				32. HOSPITAL: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b>		33. OTHER: <b>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>	
34. MANNER OF DEATH <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</b>				35. DATE OF INJURY (Month, Day, Year) <b>28a. DATE OF INJURY</b>		36. TIME OF INJURY <b>28b. TIME OF INJURY</b>	
37. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>				38. DESCRIBE HOW INJURY OCCURRED		39. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
40. CERTIFIER (Check only one) <b>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>				41. SIGNATURE AND TITLE OF CERTIFIER <i>Gregorio M. Belloso</i>		42. LICENSE NUMBER <b>D 29505</b>	
43. DATE SIGNED (Month, Day, Year) <b>2 - 16 - 94</b>				44. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GREGORIO M. BELLOSO, MD 4421 BEECHWOOD PL. CRISFIELD, MD 21817</b>		45. DATE FILED (Month, Day, Year) <b>FEB 17 1994</b>	
46. REGISTRAR'S SIGNATURE <i>Robertson-Randall</i>				47. TO BE COMPLETED BY FUNERAL DIRECTOR		48. TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	



Amended #18, 2/24/94, L.L.S., Somerset Co.

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY Hester Leatherbury</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>20</b> YEAR <b>94</b>		3. TIME OF DEATH <b>6:00 AM</b>	
4. SOCIAL SECURITY NUMBER <b>220-12-0943</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-30-1916</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>Home 31229 Charles Barnes RD.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Westover, MD.</b>		9c. COUNTY OF DEATH <b>SOMERSET</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>SOMERSET</b>		10c. CITY, TOWN OR LOCATION <b>Westover</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>31229 Charles Barnes RD</b>				10f. ZIP CODE <b>21871</b>		10g. CITIZEN OF WHAT COUNTRY? <b>Somerset</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Domestic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>House wife</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Hall Dennis</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah Dennis</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sarah Jackson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>31589 Charles Bain RD. Westover, MD. 21871</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Marumscu Cemetery</b>		20c. LOCATION — City or Town, State <b>Marumscu, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Anthony E. Ward F.D.</b>				22. NAME AND ADDRESS OF FACILITY <b>Anthony E. Ward Funeral Home 30639 HAMDEN AVE PRINCESS ANNE, MD. 21853</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial Infarction</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Generalized arteriosclerosis</b>						Approximate Interval Between Onset and Death <b>Months</b> <b>Years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA <input checked="" type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>John A. Staley, MD</b>				29c. LICENSE NUMBER <b>D10214</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/22/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>FEB 24 '94</b>				32. REGISTRAR'S SIGNATURE <b>John A. Staley</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MILDRED L. LEASE				2. DATE OF DEATH MONTH DAY YEAR February 16, 1994		3. TIME OF DEATH 05:13 a m	
4. SOCIAL SECURITY NUMBER 215-20-7453		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 27, 1921 Md	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE Md		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Westernport		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER Grandview Apts. Grandview Dr.				10f. ZIP CODE 21562		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) Johney F. Lease				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna May Emmart			
19a. INFORMANT'S NAME (Type/Print) James E. McKenzie				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 E. Main St., Lonaconing, Md. 21539			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Hill Cemetery 2-19-94		20c. LOCATION — City or Town, State Lonaconing, Md. 21539			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>RENAL FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 43497		29d. DATE SIGNED (Month, Day, Year) 2/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Daniel Leibman-Memorial Hospital-Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) FEB 18 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GEORGE EDWARD LUTKENHAUS JR				2. DATE OF DEATH MONTH DAY YEAR February 11, 1994		3. TIME OF DEATH 21:15 M			
4. SOCIAL SECURITY NUMBER 089-05-0514		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 17, 1916		8. BIRTHPLACE (State or Foreign Country) New York	
9a. FACILITY NAME (If not institution, give street and number) Harrison House Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Snow Hill			9c. COUNTY OF DEATH Worcester		
10a. STATE Maryland				10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1121 E. Church St.				10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer			16b. KIND OF BUSINESS/INDUSTRY Government				
17. FATHER'S NAME (First, Middle, Last) George Edward Lutkenhaus Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose (unk) Heimler					
19a. INFORMANT'S NAME (Type/Print) Wayne L. Lutkenhaus				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 316, Somers, NY 10589					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory		20c. LOCATION — City or Town, State Salisbury, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>SACITERIA &amp; INANITION</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>PNEUMONIA</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 1 MONTH 1 WK. 10 YRS									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ALZHEIMERS DISEASE</u>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> Dr. M. M. M.				29c. LICENSE NUMBER D-05865		29d. DATE SIGNED (Month, Day, Year) FEB. 11, 1994			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert LAMAR 104 N. BAY ST. SNOW HILL, MD 632-2330									
31. DATE FILED (Month, Day, Year) FEB 17 1994		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Gilbert Sebastian Leatherbury</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 15 1994</b>				3. TIME OF DEATH <b>7:00 P M</b>					
4. SOCIAL SECURITY NUMBER <b>214-12-5525</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 20, 1909</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Salisbury Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury, Md.</b>				9c. COUNTY OF DEATH <b>WICOMICO</b>					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Salisbury</b>				10d. INSIDE CITY LIMITS? <b>1 X YES 2 NO</b>					
10e. STREET AND NUMBER <b>611 Rose Street, Apt. 5</b>				10f. ZIP CODE <b>21801</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>							
11. MARITAL STATUS <b>1 X Never Married 2 Married 3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 X NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 X NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>None</b>									
17. FATHER'S NAME (First, Middle, Last) <b>Samuel Leatherbury</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ida Gale</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Annie Dent</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>521 Hearne Lane Salisbury, Md. 21801</b>									
20a. METHOD OF DISPOSITION <b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Acres</b>		20c. LOCATION — City or Town, State <b>Salisbury, Md.</b>		20d. DATE <b>2/19</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bladys B. Stewart</b>				22. NAME AND ADDRESS OF FACILITY <b>Clinton F. Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b>  Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>COPD</b>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's Disease</b> <b>Congestive Heart Failure</b> <b>Renal Failure</b>								Approximate Interval Between Onset and Death <b>1 Day</b>					
24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 X NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 X NO</b>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 X NO</b>		26. PLACE OF DEATH (Check only one) <b>HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA</b> <b>OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)</b>		27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>		28d. DESCRIBE NOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Michael Atkins</b>		29c. LICENSE NUMBER <b>D39813</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/16/94</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MICHAEL ATKINS, M.D., 1104 HEALTHWAY DRIVE, SALISBURY, MD. 21801</b>													
31. DATE FILED (Month, Day, Year) <b>FEB 18 1994</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JULIA ELLEN BELL LOTT</b> <i>Lott</i>				2. DATE OF DEATH MONTH <i>February</i> DAY <i>19</i> YEAR <i>1994</i>		3. TIME OF DEATH <i>3:49 A.M.</i>	
4. SOCIAL SECURITY NUMBER <b>579-03-3033</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 30, 1920</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Washington DC</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Southern Maryland Hospital Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Clinton</b>	
9c. COUNTY OF DEATH <b>Prince Georges</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>St. Mary's</b>	
10c. CITY, TOWN OR LOCATION <b>Abell</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>Clarence Gass Road, P.O.Box 152</b>	
10f. ZIP CODE <b>20606</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Home Maker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Wesley Bell, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Martha Ellen Reed</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William H. Lott, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O.Box 152, Abell, Maryland 20606</b>			
20. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Trinity Memorial Gardens 02-22-94</b>		20c. LOCATION — City or Town, State <b>Waldorf, Maryland</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark G. Brohawn</i> <b>Mark G. Brohawn M00053</b>	
22. NAME AND ADDRESS OF FACILITY <b>THE HUNT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARCINOMA OF BLADDER</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>ATHEROSCLEROTIC HEART DISEASE</b> <b>DIABETES MELLITUS</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ANEMIA</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>RBSamby</i> <b>MD FACC</b>				29c. LICENSE NUMBER <b>D27244</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-19-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print) <b>RAJ SANTANI MD 9131 PISCATAWAY RD CLINTON</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

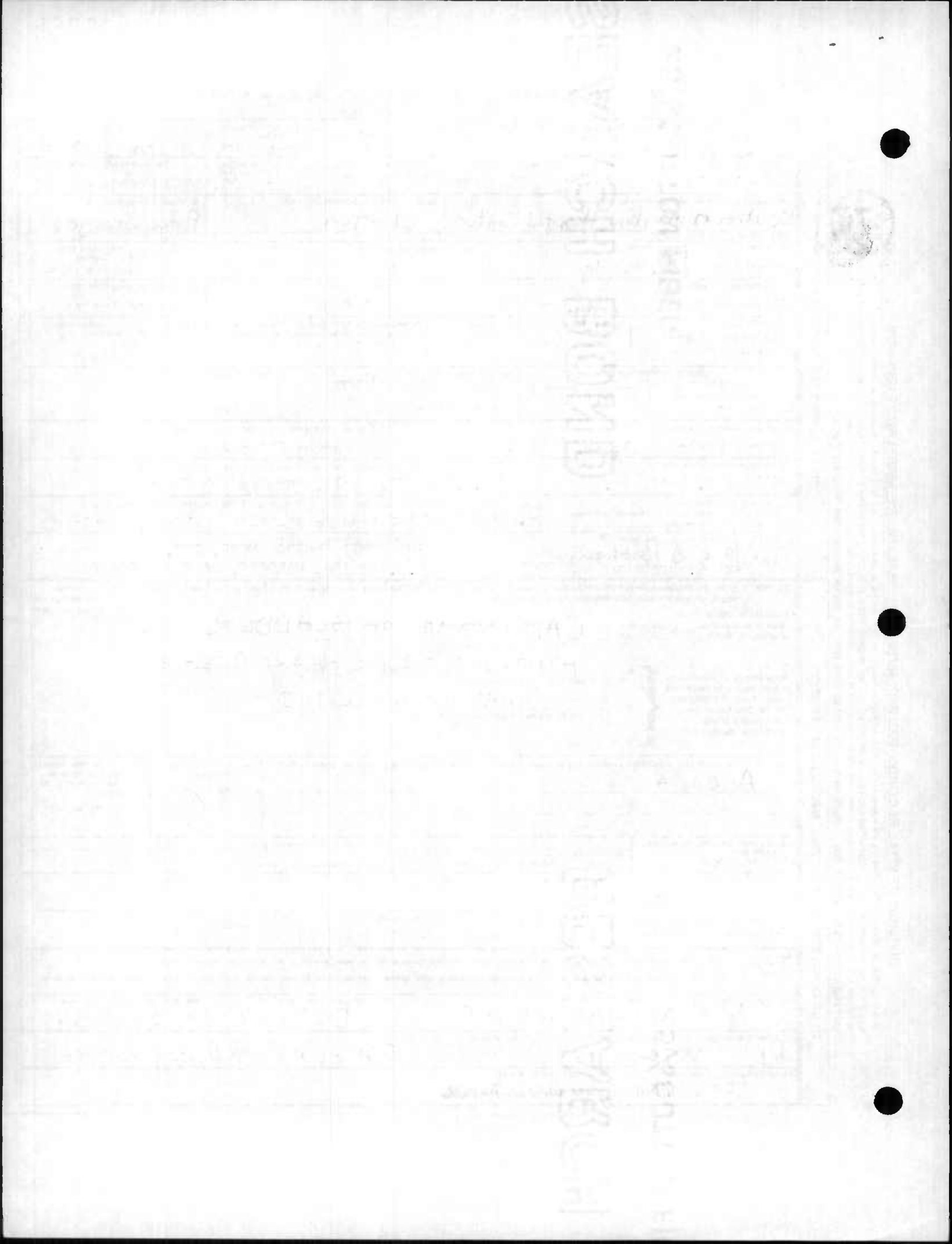
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY R MCCANN				2. DATE OF DEATH MONTH DAY YEAR 02 20 94		3. TIME OF DEATH 08:00 AM M	
4. SOCIAL SECURITY NUMBER 220-22-0883		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/7/11	
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH A.A. COUNTY	
10a. STATE MD				10b. COUNTY HARFORD		10c. CITY, TOWN OR LOCATION DARLINGTON	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 1939 CASTLETON ROAD				10f. ZIP CODE 21034		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		15b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) SAMUEL MORRIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA MURPHY			
19a. INFORMANT'S NAME (Type/Print) SUE PETTY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1939 CASTLETON RD., DARLINGTON, MD., 21034			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DUBLIN SOUTHERN CEM. 2/23/94		20c. LOCATION — City or Town, State DARLINGTON, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John H. Tillett				22. NAME AND ADDRESS OF FACILITY HARKINS F.H. INC., DELTA, PA., 17314			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Cardiopulmonary arrest</u>					
		b. <u>Acute myocardial infarction</u>					
		c. <u>Chronic obstructive heart disease</u>					
		d.					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>COPD</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Ira E. Kaplan				29c. LICENSE NUMBER D25611		29d. DATE SIGNED (Month, Day, Year) 2/21/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) IRA E. KAPLAN, M.D./7845 OAKWOOD ROAD, #200/GLEN BURNIE, MARYLAND 21061							
31. DATE FILED (Month, Day, Year) FEB 24 '94		32. REGISTRAR'S SIGNATURE J. A. Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the basis for the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06766

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DORA MORTZFELDT				2. DATE OF DEATH MONTH DAY YEAR February 15, 1994		3. TIME OF DEATH 2:22 A M	
4. SOCIAL SECURITY NUMBER 219-14-7158		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb 24, 1908	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital & Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 130 Potomac Street				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) supervisor		16b. KIND OF BUSINESS/INDUSTRY School cafeteria			
17. FATHER'S NAME (First, Middle, Last) Jacob Getz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Shreve			
19a. INFORMANT'S NAME (Type/Print) J. Ray Getz				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 183; Ridgeley, WV 26753			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilicrest Burial Park 02/17		20c. LOCATION — City or Town, State Cumberland, Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jonas Z. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial Infarction</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Fiscus</i>				29b. LICENSE NUMBER D 12779		29c. DATE SIGNED (Month, Day, Year) 2/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CRUISE OF DEATH (ITEM 27) (Type, Print) Dr. Fiscus, Memorial Hospital Medical Building Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) FEB 17 1994				32. REGISTRAR'S SIGNATURE <i>Julia Benson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 06767

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BERNARD FRANCIS MCGANN</b>				2. DATE OF DEATH MONTH <b>FEBRUARY</b> DAY <b>12</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>12:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>213 12 9167</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jul 9, 1922</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>WV</b>				10b. COUNTY <b>Mineral</b>		10c. CITY, TOWN OR LOCATION <b>Wiley Ford</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>P.O. Box 215</b>			
10f. ZIP CODE <b>26767</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>electrician</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Railroad</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Francis J. McGann</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth C. Ruppert</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy M. McGann</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 215; Wiley Ford, Wv 26767</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Restlawn Memorial Gardens 02-15</b>		20c. LOCATION — City or Town, State <b>LaVale, MD</b>		20d. DATE <b>02-15</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>congestive heart failure</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <b>Coronary artery disease</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>left bundle branch block</b> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Lung Cancer in brain metastases</b> <b>diabetes mellitus</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>R. Espina, MD</b>				29c. LICENSE NUMBER <b>1103459</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/14/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R. ESPINA, MD 902 SETON DRIVE, CUMBERLAND, MD</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 17 1994</b>				32. REGISTRAR'S SIGNATURE <b>John Benison-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0060  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>SARAH</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>18</b> YEAR <b>94</b>				3. TIME OF DEATH <b>10:12 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214 05 4039</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2/21/01</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>427A ARCH STREET</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>				9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ALLEGANY</b>		10c. CITY, TOWN OR LOCATION <b>CUMBERLAND</b>				10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>	
10e. STREET AND NUMBER <b>427A ARCH STREET</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>8</b> Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ACCOUNTANT</b>		16b. KIND OF BUSINESS/INDUSTRY <b>NEWSPAPER</b>					
17. FATHER'S NAME (First, Middle, Last) <b>JOHN BERKENBAUGH</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HELEN E. BREHANY</b>					
19a. INFORMANT'S NAME (Type/Print) <b>ANN BERKENBAUGH SUTER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>111 OAK ST., CUMBERLAND, MD 21502</b>					
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ST. MARY'S CEMETERY</b>		DATE <b>2/21</b>		20c. LOCATION — City or Town, State <b>CUMBERLAND, MD 21502</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Maureen M. Sowers</i>				22. NAME AND ADDRESS OF FACILITY <b>SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Congestive heart failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Aortic stenosis (valvular) (present 110 years 67 years)</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Atherosclerotic cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death <b>2 wks</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>							
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29b. SIGNATURE AND TITLE OF CERTIFIER <i>John M. Walsh MD FACP</i>							
		29c. LICENSE NUMBER <b>D13601</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/21/94</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>925 Bishop Walsh Dr. Cumberland, MD 21502</b>									
31. DATE FILED (Month, Day, Year) <b>2/21/94</b>		32. REGISTRAR'S SIGNATURE <i>John M. Walsh</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000 10 10  
J. J. J.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ORVILLE LLOYD MIDYETT</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>22</b> YEAR <b>94</b>		3. TIME OF DEATH <b>7:45 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>201-24-2948</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>61</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 15, 1932</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Tennessee</b>				9a. FACILITY NAME (If not institution, give street and number) <b>11404 Featherbed Lane</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>	
9c. COUNTY OF DEATH <b>Allegany</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Allegany</b>	
10c. CITY, TOWN OR LOCATION <b>Cumberland</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>11404 Featherbed Lane</b>	
10f. ZIP CODE <b>21502</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use ratings.) <b>Self-employed Sales/Distribution</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Greeting Cards</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John W. Midyett</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nina (Capps)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Frances Williams</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7008 Eighth Road Bartlett, TN 38135</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE <b>Sunnyside Cemetery 2/25/94</b>			
20c. LOCATION — City or Town, State <b>Kenton, TN</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>S. Mark Sings</b>			
22. NAME AND ADDRESS OF FACILITY <b>George-Upchurch Funeral Home, P.A. 202 Greene St Cumb, MD 21502</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Coronary Artery Disease</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>28b. TIME OF INJURY</b> <b>M</b> <b>28c. INJURY AT WORK?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>28d. DESCRIBE HOW INJURY OCCURRED</b> <b>28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)</b> <b>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</b>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>William D. Lamm M.D.</b>			
29c. LICENSE NUMBER <b>D25406</b>				29d. DATE SIGNED (Month, Day, Year) <b>2-24-94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William D. Lamm, M.D. - 47 Virginia Ave.-Cumberland, MD 21502</b>				31. DATE FILED (Month, Day, Year) <b>FEB 25 1994</b>			
32. REGISTRAR'S SIGNATURE <b>John B. ...</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY MITCHELL MILLS				2. DATE OF DEATH FEBRUARY 21, 1994		3. TIME OF DEATH 9:37 P M	
4. SOCIAL SECURITY NUMBER 218-24-0867		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 3, 1915	
9a. FACILITY NAME (If not institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH LA PLATA		9c. COUNTY OF DEATH CHARLES	
10a. STATE Maryland				10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION Indian Head	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER #1 Maple Street		10f. ZIP CODE 20640	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nursing Assistant				16b. KIND OF BUSINESS/INDUSTRY Medical		17. FATHER'S NAME (First, Middle, Last) John Henry Mitchell	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Macie Gertrude Wheeler				19a. INFORMANT'S NAME (Type/Print) Chester Mitchell Mills		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) #1 Maple St., Indian Head, MD 20640	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Park Hill Cemetery 2-24		20c. LOCATION — City or Town, State Marbury, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Benjamin Matthews M00053				22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604-0156		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE CEREBRAL HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF): b. HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Aurelio C. de la Paz, M.D.		29c. LICENSE NUMBER D-16160	
29d. DATE SIGNED (Month, Day, Year) 02-22-94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AURELIO C. DE LA PAZ, MD. P.O. BOX 1230 LA PLATA, MARYLAND 20646		31. DATE FILED (Month, Day, Year) FEB 24 1994	
32. REGISTRAR'S SIGNATURE John Davidson-Randall				33. DATE OF DEATH FEB 21 1994		34. TIME OF DEATH 9:37 P M	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 06771

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BETTY WILSON MAXWELL</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>15</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>7:45 p m</b>	
4. SOCIAL SECURITY NUMBER <b>218-16-8965</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-19-1925</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>403 D WOODVIEW SQUARE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
10a. STATE <b>FLORIDA</b>				10b. COUNTY <b>VALUSIA</b>		10c. CITY, TOWN OR LOCATION <b>EDGEWATER</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>P.O. BOX 971</b>			
10f. ZIP CODE <b>32141</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+) <b>1</b>		16a. DECEDENT'S USUAL OCCUPATION (One kind of work done during most of working life. Do NOT use retired.) <b>BEAUTICIAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BEAUTY SHOP</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ULYSSES V. WILSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LUEY PHILLIPS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DOUGLAS H. MAXWELL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>403 D. WOODVIEW SQUARE, SALISBURY, MD.</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SPRINGHILL MEM. GRDS. 2-18</b>		20c. LOCATION — City or Town, State <b>HEBRON, MARYLAND</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>	
22. NAME AND ADDRESS OF FACILITY <b>BOUNDS FUNERAL HOME, SALISBURY, MD.</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Concussion of pancreas</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>28b. TIME OF INJURY</b> <b>28c. INJURY AT WORK?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>28d. DESCRIBE HOW INJURY OCCURRED</b> <b>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</b>	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <b>D30693</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/16/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>560 Riverside Dr. Salisbury, Md.</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 17 1994</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM BRADFORD MARSHALL</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>15</b> YEAR <b>94</b>		3. TIME OF DEATH <b>0925</b> <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>215-36-1198</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>55</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02-26-38</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
10a. STATE <b>Md</b>		10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Parsonsbury</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5920 Forest Grove Road</b>				10f. ZIP CODE <b>21849</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <b>2</b> <input checked="" type="checkbox"/> Married		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Merchant</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Retail Sales</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Bradford Marshall</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Elizabeth Jenkins</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gwen A. Marshall</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5920 Forest Grove Road, Parsonsbury, Md 21849</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Downing Cemetery Feb. 19, 1994</b>		20c. LOCATION — City or Town, State <b>Oak Hall, Va.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> <b>MOO-417</b>				22. NAME AND ADDRESS OF FACILITY <b>Messick Funeral Home, P.O. Box 61 Bivalve, Maryland 21814</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CORONARY OCCLUSION</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>d. RHEUMATOID ARTHRITIS</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death <b>HOURS</b>  <b>YEARS</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> <b>RHEUMATOID ARTHRITIS</b>						24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> <b>DEPUTY M.E.</b>				29c. LICENSE NUMBER <b>D03599</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-15-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MARYLAND, 21801</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 17 1994</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEMS: 23 PART I, 27, PER MEO FILM G-709 3/17/94 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BRIANNA LOUISE MOLITOR</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB 23, 1994</b>		3. TIME OF DEATH <b>8:07 AM</b>					
4. SOCIAL SECURITY NUMBER <b>n/a</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS <b>1 15</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 8, 1994</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>UNION HOSPITAL of Cecil County</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ELKTON</b>			9c. COUNTY OF DEATH <b>CECIL</b>				
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Cecil</b>		10c. CITY, TOWN OR LOCATION <b>North East</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>100A South Main Street</b>				10f. ZIP CODE <b>21901</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>n/a</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>n/a</b>			16b. KIND OF BUSINESS/INDUSTRY <b>n/a</b>						
17. FATHER'S NAME (First, Middle, Last) <b>Michael Molitor</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Kristiana Simmons</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Kristiana Simmons</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>100A South Main Street - North East, MD 21901</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Elkton Cemetery</b>			20c. DATE <b>2-26-1994</b>		20d. LOCATION — City or Town, State <b>Elkton, Maryland</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Donald G. Wright</b>				22. NAME AND ADDRESS OF FACILITY <b>Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SUDDEN INFANT DEATH SYNDROME</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> XER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Donald G. Wright MD</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>			29d. DATE SIGNED (Month, Day, Year) <b>FEB 24, 1994</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use with the funeral-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06774

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Madeline Virginia Miller</b>				2. DATE OF DEATH MONTH DAY YEAR <b>02 16 1994</b>		3. TIME OF DEATH <b>7:00 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>214/74/0821</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>08/06/1904</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Harrison House Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Snow Hill</b>	
9c. COUNTY OF DEATH <b>Worcester</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Worcester</b>	
10c. CITY, TOWN OR LOCATION <b>Pocomoke City</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>Front Street</b>	
10f. ZIP CODE <b>21851</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Housewife</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Charles William Duncan Taylor</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Virginia Cutler</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Kathryn E. Kolb</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1106 Camden Ave., Salisbury, Md. 21801</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>First Baptist Cemetery 2/19</b>		20c. LOCATION — City or Town, State <b>Pocomoke City, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott S. Melson</i>				22. NAME AND ADDRESS OF FACILITY <b>Melson Funeral Home PO BOX 64, Pocomoke City, Md. 21851</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or final failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ISCHEMIC CARDIOMYOPATHY</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>ARTERIOSCLEROTIC HEART DISEASE</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>GENERALIZED ATHEROSCLEROSIS</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>1. ALZHEIMER'S DISEASE 2. ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE 3. GLAUCOMA RECURRENT URINARY INFECTION</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. J. Belloso</i>				29c. LICENSE NUMBER <b>D 29505</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-16-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GREGORIO M. BELLOSO 4421 BEECHWOOD PL, CRISFIELD, MD 21817</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>				32. REGISTRAR'S SIGNATURE <i>John B. Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 06775

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ESTHER BEATRICE NULL				2. DATE OF DEATH MONTH DAY YEAR February 21, 1994		3. TIME OF DEATH 9:20 a m	
4. SOCIAL SECURITY NUMBER 232-26-1799		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 11, 1907	
8. BIRTHPLACE (State or Foreign Country) WEST VIRGINIA		9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE WEST VA		10b. COUNTY MINERAL		10c. CITY, TOWN OR LOCATION KEYSER		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER ROUTE 2 - SILVER TREE Apartments				10f. ZIP CODE 26726		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (1-4 or 5+) College		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		15b. KIND OF BUSINESS/INDUSTRY HOME			
17. FATHER'S NAME (First, Middle, Last) JACOB E. MALONE				18. MOTHER'S NAME (First, Middle, Maiden Surname) LENA FRANCES BROOME			
19a. INFORMANT'S NAME (Type/Print) DAISY NULL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 307 - FT. ASHBY, WV 26719			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FT. ASHBY CEMETERY 2-23-94		20c. LOCATION — City or Town, State FT. ASHBY, WV			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles G. Upchurch</i>				22. NAME AND ADDRESS OF FACILITY FT. ASHBY FUNERAL HOME, INC. P.O. BOX 1260-FT. ASHBY, WV 26719			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Enter stroke heart disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Guy Fiscus</i>				29c. LICENSE NUMBER D 12779		29d. DATE SIGNED (Month, Day, Year) 2-22-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Guy Fiscus-Memorial Hospital Medical Building-Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) FEB 25 1994				32. REGISTRAR'S SIGNATURE <i>John Benison-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Jerry Newsome Jr.</b>				2. DATE OF DEATH MONTH <b>FEB.</b> DAY <b>11</b> YEAR <b>1994</b>				3. TIME OF DEATH <b>1445</b> M	
4. SOCIAL SECURITY NUMBER <b>242-40-7710</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>September 6, 1928</b>		8. BIRTHPLACE (State or Foreign Country) <b>NC</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>				9c. COUNTY OF DEATH <b>WICOMICO</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Salisbury</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>405 Claybourne Street</b>		10f. ZIP CODE <b>21801</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Unknown</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Labor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Education</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Jerry Newsome, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rosa Britt</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Anna Purnell</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>405 Calibourne Street - Salisbury, MD 21801</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Phillip Baptist Ch. Cem. 2/18</b>		20c. LOCATION — City or Town, State <b>Cofield, NC</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barrell A. Fooks</i>				22. NAME AND ADDRESS OF FACILITY <b>Fooks Funeral Service 917 W. Isabella Street - Salisbury, MD 21801</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Lymphocytic leukemia - Aggressive</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHF, COPD- Resp. Failure, morbid obesity, peptic ulcer disease</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Deepak Saggal MD</i>				29c. LICENSE NUMBER <b>018614</b>	
29d. DATE SIGNED (Month, Day, Year) <b>2.12.94</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DEEPAK SAGGAL 547E RIVERSIDE DRIVE, SALISBURY MD. 21801</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 17 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ALUMINUM

ALUMINUM

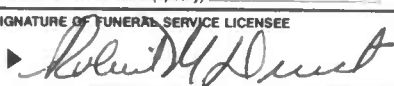
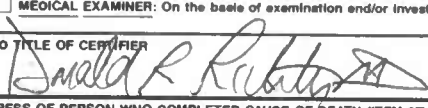
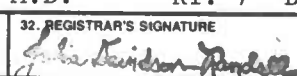
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94 06777

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN REBECCA PRICE				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 15, 1994		3. TIME OF DEATH 8:43 A M	
4. SOCIAL SECURITY NUMBER 219-01-8923		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 13, 1906	
9a. FACILITY NAME (If not institution, give street and number) DENNETT ROAD MANOR NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH OAKLAND		9c. COUNTY OF DEATH GARRETT	
10a. STATE MARYLAND				10b. COUNTY GARRETT		10c. CITY, TOWN OR LOCATION MT. LAKE PARK	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 514 L STREET				10f. ZIP CODE 21550		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) JESSE DWYER				18. MOTHER'S NAME (First, Middle, Maiden Surname) ADA BENJAMIN			
19a. INFORMANT'S NAME (Type/Print) JOYCE A. HUMPAL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5315 FORREST LAWN CR. McFARLAND, WISCONSIN 53558			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) OMEGA CREMATORY		20c. DATE 2/16		20d. LOCATION — City or Town, State MORGANTOWN, W. VA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00167				22. NAME AND ADDRESS OF FACILITY P.O. BOX 243 DURST FUNERAL HOME — OAKLAND, MD. 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic cardiovascular disease							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Cerebrovascular disease							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D30035		29d. DATE SIGNED (Month, Day, Year) 2/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD R. RICHTER, M.D. RT. 7 BOX 1495 OAKLAND, MD. 21550							
31. DATE FILED (Month, Day, Year) FEB 16 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


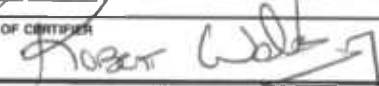
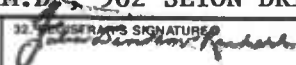


94 06778

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT ELWOOD PRITTS</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>15</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>05:35</b> M			
4. SOCIAL SECURITY NUMBER <b>165-22-0218</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-28-29</b>		8. BIRTHPLACE (State or Foreign Country) <b>Pa.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND, MD.</b>			9c. COUNTY OF DEATH <b>ALLEGANY</b>		
RESIDENCE OF DECEDENT									
10a. STATE <b>Pa.</b>		10b. COUNTY <b>Somerset Co.</b>		10c. CITY, TOWN OR LOCATION <b>Salisbury</b>			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>RD-1</b>				10f. ZIP CODE <b>15558</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Operator- Heavy Equip.</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Roy Pritts</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Grace Watson</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Maxine Pritts</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RD-1 Salisbury, Pa. 15558</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Union Cemetery</b>		DATE <b>2-17-94</b>		20c. LOCATION — City or Town, State <b>Meyersdale, Pa.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>11249</b>				22. NAME AND ADDRESS OF FACILITY <b>W. R. Price Funeral Home, Inc.</b> <b>325 Main St. Meyersdale, Pa. 15552</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ELECTROLYTE DISORDER</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>b. ACUTE MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. CORONARY ARTERY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. DIABETES MELLITUS</b>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>END STAGE RENAL DISEASE</b> <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>								Approximate Interval Between Onset and Death	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY <b>M</b>		26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURRED	
26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER  <b>DR. ROBERT WELIK, M.D.</b>		29c. LICENSE NUMBER <b>D31875</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/15/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. ROBERT WELIK, M.D., 902 SETON DRIVE, CUMBERLAND, MD 21502</b>									
31. DATE FILED (Month, Day, Year) <b>FEB 18 1994</b>				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





PARK, MARY

94 06779

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mary W. Park</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 21, 1994</b>		3. TIME OF DEATH <b>11:30 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>218-16-3911</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 1, 1918</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Wv.</b>				9. COUNTY OF DEATH <b>Frederick</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick, Md</b>			
10a. STATE <b>Md.</b>				10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Frederick Md.</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1900 Rosemont Av.</b>			
10f. ZIP CODE <b>21702</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (14 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Food Retail</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Watson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Minnie Trnum</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Iva D. Poole</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6807 Picnicwoods Rd. MIDDLETOWN, MD.</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Woodmere Cemetery</b>		20c. LOCATION — City or Town, State <b>2-26-94 Detroit, Mich.</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wm H. H. H. H.</i>	
22. NAME AND ADDRESS OF FACILITY <b>31 Jones St. Fredlock Funeral Home Piedmont, Wv.</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Severe End stage COPD</b> DUE TO (OR AS A CONSEQUENCE OF): <b>LLL Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>John S. Gritson M.D.</i>		29c. LICENSE NUMBER <b>D21944</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/21/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John S. Gritson M.D. 1475 TANGY AVE, Suite 204, FREDERICK MD</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 24 1994</b>		32. REGISTRAR'S SIGNATURE <i>John S. Gritson</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Theresa M. Prinelli</i>				2. DATE OF DEATH MONTH DAY YEAR <i>FEBRUARY 12, 1994</i>				3. TIME OF DEATH <i>0320 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>145-05-1477</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>82</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>July 12, 1911</i>		8. BIRTHPLACE (State or Foreign Country) <i>New York</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>PENINSULA REGIONAL MEDICAL CENTER</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>SALISBURY</i>				9c. COUNTY OF DEATH <i>WICOMICO</i>	
RESIDENCE OF DECEDENT									
10a. STATE <i>Virginia</i>		10b. COUNTY <i>Accomack</i>		10c. CITY, TOWN OR LOCATION <i>Chincoteague</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>6319 Mumford Street</i>				10f. ZIP CODE <i>23336</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (13-16) <i>5+</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>			16b. KIND OF BUSINESS/INDUSTRY <i>Self</i>		
17. FATHER'S NAME (First, Middle, Last) <i>Giuseppe Nicola Menchini</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Angelina Battaglino</i>					
19a. INFORMANT'S NAME (Type/Print) <i>John A. Prinelli Jr.</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) <i>6319 Mumford Street, Chincoteague, Virginia 23336</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of place, date) <i>Saint Andrew Cemetery</i>			20c. LOCATION — City or Town, State <i>River Vale, New Jersey</i>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Constance Salyn Bond</i>				22. NAME AND ADDRESS OF FACILITY <i>Salyn Funeral Home Chincoteague, Virginia 23336</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stephen Pavlos MD</i>					
				29c. LICENSE NUMBER <i>D41721</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/12/94</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>STEPHAN PAVLOS 560 RIVERSIDE DR. B101 SALISBURY MD. 21801</i>									
31. DATE FILED (Month, Day, Year) <i>FEB 15 1994</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELIZABETH D. PAPARELLA</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>16</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>11:05pm</b>	
4. SOCIAL SECURITY NUMBER <b>041-20-6807</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>75</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>3-3-1918</b>	
8. BIRTHPLACE (State or Foreign Country) <b>CONNECTICUT</b>				9a. FACILITY NAME (If not institution, give street and number) <b>715 EDGEWATER DR. APT. 104</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>	
9c. COUNTY OF DEATH <b>WICOMICO</b>				10a. STATE <b>MD.</b>		10b. COUNTY <b>WICOMICO</b>	
10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>715 EDGEWATER DR.</b>	
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>X</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TEACHER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>PUBLIC SCHOOL</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JOHN J. DEEGAN SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY McMAHON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MICHAEL W. PAPARELLA</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>715 EDGEWATER DR. APT 104 SALISBURY, MD.</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SPRINGHILL MEM. GRDS, 2-19</b>		20c. LOCATION — City or Town, State <b>HEBRON, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>BOUNDS FUNERAL HOME, SALISBURY, MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>severe chronic obstructive lung Disease</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>2 yrs</b>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mary L Fleury MD</i>				29c. LICENSE NUMBER <b>D24871</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/18/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print) <b>570 Riverside Drive Salisbury MD - Mary L Fleury</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 18 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \_\_\_\_\_ hours after death. Page 6 may be retained by the hospital or attending physician.

**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CLIFTON VAN ROBY</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>12</b> YEAR <b>94</b>		3. TIME OF DEATH <b>8:45a M</b>	
4. SOCIAL SECURITY NUMBER <b>214-07-5482</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov 12, 1914</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>MEMORIAL HOSPITAL &amp; MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND, MARYLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>519 Marietta Street</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>broadcaster</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Radio/Television</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Clifton Van Roby</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Harriett Grimes</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy Roby</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>519 Marietta Street; Cumberland, MD 21502</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sunset Memorial Park</b>		20c. LOCATION — City or Town, State <b>02/15 Cumberland, MD</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Anorexia; Nausea Vomiting</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Advanced Carcinoma Prostate</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Diffuse BONY METASTASIS.</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Depression</b>							Approximate Interval Between Onset and Death <b>6 weeks 4 yrs.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D 23371</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/14/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Qamar Zaman, M.D., Suite 102, 625 Kent Ave., Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 17 1994</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LAWRENCE P. REPHANN</b>				2. DATE OF DEATH MONTH <b>February</b> DAY <b>17</b> , YEAR <b>1994</b>				3. TIME OF DEATH <b>11:06 P M</b>	
4. SOCIAL SECURITY NUMBER <b>220-74-3222</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov 19, 1919</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>				9c. COUNTY OF DEATH <b>Allegany</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>Allegany</b>				10c. CITY, TOWN OR LOCATION <b>Cumberland</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>14405 Rephann Lane SW</b>				10f. ZIP CODE <b>21502</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>none</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>none</b>				16b. KIND OF BUSINESS/INDUSTRY <b>n/a</b>				17. FATHER'S NAME (First, Middle, Last) <b>William Rephann</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ella C. Dunn</b>				19a. INFORMANT'S NAME (Type/Print) <b>Katherine Stein</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14405 Rephann Lane SW Cumberland MD 21502</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Mary's Cemetery 2/19/</b>				20c. LOCATION — City or Town, State <b>Cumberland MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James Z. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, Maryland 21502</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>BACTERIAL PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  <b>RHEUMATOID ARTHRITIS</b>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Daniel Leibman</i>				29c. LICENSE NUMBER <b>D 43497</b>				29d. DATE SIGNED (Month, Day, Year) <b>2/17/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Daniel Leibman M.D. Memorial Hospital Cumberland, MD 21502</b>				31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>				32. REGISTRAR'S SIGNATURE <i>James Z. Scarpelli</i>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1978-1979

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HERBERT FRANKLIN RINGER</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>21</b> YEAR <b>94</b>		3. TIME OF DEATH <b>0450 A M</b>	
4. SOCIAL SECURITY NUMBER <b>220-16-5799</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>05 03 06</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Garrett</b>		10c. CITY, TOWN OR LOCATION <b>Grantsville</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>136 Main St.</b>				10f. ZIP CODE <b>21536</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5 th</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mechanic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Auto</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Albert Ringer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Cramer</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Charles R. Ringer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6567 Lincoln Way West, St. Thomas, PA 17252</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Paul's Lutheran Cem. 12-23</b>		20c. LOCATION — City or Town, State <b>Fort Hill, PA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alfred Newman</i>				22. NAME AND ADDRESS OF FACILITY <b>Newman Funeral Homes, P.A. 155 Main St., Grantsville, MD 21536</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiorespiratory arrest</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Brainstem + Cerebellar Hemorrhage</b> <b>Hypertension</b> <b>Pneumonia</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D22029</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/21/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RIAZ A. JANJUA, M.D. - 625 Kent Ave, Cumberland, Md</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 24 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RICHARD Emerson ROBERTS Jr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 17, 1994</b>		3. TIME OF DEATH <b>23:00</b>	
4. SOCIAL SECURITY NUMBER <b>219 34 6766</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>57</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 15, 1936</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>CALVERT MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>PRINCE FREDERICK</b>		9c. COUNTY OF DEATH <b>CALVERT</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Calvert</b>		10c. CITY, TOWN OR LOCATION <b>Prince Frederick</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>112 Dares Beach Road</b>				10f. ZIP CODE <b>20678</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>carpenter</b>		16b. KIND OF BUSINESS/INDUSTRY <b>construction</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Richard Emerson Roberts Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Myrtle Elliott</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Carol J. Roberts</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 1025 Prince Frederick, Maryland 20678</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Wesley Cemetery 2/21/94</b>		20c. LOCATION — City or Town, State <b>Prince Frederick MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>B. Rausch</b>				22. NAME AND ADDRESS OF FACILITY <b>Rausch Funeral Home P.A. 4405 Broomes Is. Rd. Port Republic, Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Disease CANCER</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <b>LIVER</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>Hepatic coma.</b> c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Issam Damalouji</b>				29c. LICENSE NUMBER <b>D03077</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/18/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Issam Damalouji Prince Frederick, Maryland 20678</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randell</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



OFFICE OF THE DIRECTOR

U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

RECEIVED

DEPT. OF AGRICULTURE

WASHINGTON, D.C.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RICHARD GARY SHAW				2. DATE OF DEATH MONTH DAY YEAR February 15, 1994		3. TIME OF DEATH 2:02 A M	
4. SOCIAL SECURITY NUMBER 216-38-5082		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN. 8 1937	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland	
9c. COUNTY OF DEATH Allegany				10a. STATE MARYLAND		10b. COUNTY ALLEGANY	
10c. CITY, TOWN OR LOCATION CUMBERLAND				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 18 SOUTH MECHANIC STREET	
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Dis. - 1956				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 10 College (1-4 or 5+) 10				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MOVING TRANSFER CO.		16b. KIND OF BUSINESS/INDUSTRY LABORER	
17. FATHER'S NAME (First, Middle, Last) ROY HOWARD SHAW				18. MOTHER'S NAME (First, Middle, Maiden Surname) BEULAH MAY VANNOY			
19a. INFORMANT'S NAME (Type/Print) RICHARD SHAW JR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RFD#8 BOX# 287A VALLEY ROAD CUMBERLAND MARYLAND			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) ROCKY GAP VET CEMETERY FEB 18 1994		20c. LOCATION — City or Town, State FLINTSTONE MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dale L. Merritt				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute renal Failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Scleroderma Interstitial Lung Disease						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Dr. R. Barrera			
29c. LICENSE NUMBER D 14865				29d. DATE SIGNED (Month, Day, Year) 2-15-94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. R. Barrera, Memorial Hospital Medical Bldg., Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) FEB 16 1994				32. REGISTRAR'S SIGNATURE John Barrera			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06789

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DAVID EVERETT SPRINGER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 12 1994</b>		3. TIME OF DEATH M <b>22:50</b>	
4. SOCIAL SECURITY NUMBER <b>218-16-3687</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 31, 1923</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND, MD.</b>	
9c. COUNTY OF DEATH <b>ALLEGANY</b>				10a. STATE <b>MARYLAND</b>			
10b. COUNTY <b>ALLEGANY</b>				10c. CITY, TOWN OR LOCATION <b>PINTO</b>			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>JARED DRIVE</b>			
10f. ZIP CODE <b>21556</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W.II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>LABORER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>LOCAL #616</b>	
17. FATHER'S NAME (First, Middle, Last) <b>EDWARD SPRINGER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CARRIE HARR</b>			
19a. INFORMANT'S NAME (Type/Print) <b>RITA VANMETER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RT. 3, BOX 246 - RAWLINGS, MD 21557</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>RESTLAWN MEML. GARDENS 2/15/94</b>		20c. LOCATION — City or Town, State <b>LA VALE, MD</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wendy D. Upchurch</i>				22. NAME AND ADDRESS OF FACILITY <b>GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b>							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
a. <b>Ca lung metastatic</b> b. <b>Bran</b> c. <b></b> d. <b></b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Uriel Velandia</i>				29c. LICENSE NUMBER <b>DO 2377</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-15-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. URIEL VELANDIA, M.D., 924 SETON DRIVE, CUMBERLAND, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 16 1994</b>				32. REGISTRAR'S SIGNATURE <i>John B. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>IVA ELIA STIMMONS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 15, 1994</b>		3. TIME OF DEATH M <b>3:20A</b>	
4. SOCIAL SECURITY NUMBER <b>233-96-3667</b>		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jul 31, 1901</b>	
9a. FACILITY NAME (if not institution, give street and number) <b>Memorial Hospital &amp; Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
10a. STATE <b>WV</b>				10b. COUNTY <b>Mineral</b>		10c. CITY, TOWN OR LOCATION <b>Ridgeley</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>187 Main Street</b>			
10f. ZIP CODE <b>26753</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>homemaker</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>own home</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Ivy Whittle</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nannie Murphy</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Rosaleen Liller</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Box 234; Ridgeley, WV 26753</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Abe Cemetery</b>		20c. DATE <b>02-20</b>		20d. LOCATION — City or Town, State <b>Short Gap, WV</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebrovascular Accident</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>CAD</b> <b>ASCVD = OVI + CVI</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29c. LICENSE NUMBER <b>D 16041</b>
29d. DATE SIGNED (Month, Day, Year) <b>2-15-94</b>							29e. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. T. Williams</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. T. Williams Memorial Hospital Medical Building Cumberland, Md 21502</b>							31. DATE FILED (Month, Day, Year) <b>FEB 17 1994</b>
32. REGISTRAR'S SIGNATURE <b>John Benson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit (pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY D. SHAFFER</b>				2. DATE OF DEATH MONTH <b>February</b> DAY <b>16</b> , YEAR <b>1994</b>		3. TIME OF DEATH <b>6:55 AM</b>	
4. SOCIAL SECURITY NUMBER <b>220-03-7943</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-18-1918</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Mt. Savage</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>104 Upper New Row</b>				10f. ZIP CODE <b>21545</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Teachers Aide</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>County Schools</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Blake</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Burkey</b>			
19a. INFORMANT'S NAME (Type/Print) <b>George R. Shaffer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18 Scott Court, Cumberland, Md. 21502</b>			
20. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>St. Patrick's Cemetery 2/18</b>		20c. LOCATION — City or Town, State <b>Mt. Savage, Md.</b>		20d. DATE <b>2/18</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John P. Hawn</i>				22. NAME AND ADDRESS OF FACILITY <b>Durst Funeral Home, Frostburg, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CIRRHOSIS</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MASSIVE ASCITES</b> <b>MASSIVE PLEURAL EFFUSION</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. D. Leibman MD</i>				29c. LICENSE NUMBER <b>D 43497</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/17/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. D. Leibman, Memorial Hospital &amp; Medical Center, Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>				32. REGISTRAR'S SIGNATURE <i>John P. Hawn</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Edgar W. Shoemaker</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 19, 1994</b>		3. TIME OF DEATH <b>7:50 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>213-10-9684</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 1, 1914</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Rear 33 Blair St.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frostburg</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Frostburg</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Rear 33 Blair St.</b>				10f. ZIP CODE <b>21532</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W. 2</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Driver</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Beer Distributor</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Shoemaker</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bertha Short</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John W. Shoemaker</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>31 Blair St., Frostburg, Md. 21532</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rocky Gap Veterans Cem.</b>		20c. DATE <b>2/22</b>		20d. LOCATION — City or Town, State <b>Flintstone, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John P. Horn</i>				22. NAME AND ADDRESS OF FACILITY <b>Durst Funeral Home, Frostburg, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary Artery Heart Disease</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>Years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>John W. Shoemaker</i> <b>Dept Med Ex.</b>		29c. LICENSE NUMBER <b>D 09157</b>		29d. DATE SIGNED (Month, Day, Year) <b>Feb. 19, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Paul Snow, M.D., 124 W. 3rd St., Cumberland, Md. 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>		32. REGISTRAR'S SIGNATURE <i>John D. Anderson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>REBECCA ARMSTRONG SPEIR</b>				2. DATE OF DEATH MONTH <b>FEB.</b> DAY <b>20</b> YEAR <b>94</b>		3. TIME OF DEATH <b>12:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>212 10 6272</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10/23/17</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>226 WELSH HILLS APT. #F-</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>FROSTBURG</b>		9c. COUNTY OF DEATH <b>MARYLAND</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ALLEGANY</b>		10c. CITY, TOWN OR LOCATION <b>FROSTBURG</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>226 WELSH HILL APARTMENT F</b>				10f. ZIP CODE <b>21532</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ADMINISTRATIVE SECRETARY</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CIVIL SERVICE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>DAVID T. ADAMS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNIE JOHNSTONE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>WILLIAM J. SPEIR</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>LEGISLATIVE ROAD, FROSTBURG, MD 21532</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>FROSTBURG MEMORIAL PARK 2/23</b>		20c. LOCATION — City or Town, State <b>FROSTBURG, MD 21532</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Maile M. Sowers</i>				22. NAME AND ADDRESS OF FACILITY <b>SOWERS FUNERAL HOME 60 W. MAIN ST., FROSTBURG, MD 21532</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Atherosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Fatty Liver, Chronic Alcoholism Breast Cancer Tobacco Use</i>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>XX</b> YES 2 <input type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute MD</i>		29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB. 21, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DENNIS J. CHUTE 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>		32. REGISTRAR'S SIGNATURE <i>John Benison-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LUTHER W SCHRAMM</b>				2. DATE OF DEATH MONTH DAY YEAR <b>02 23 94</b>		3. TIME OF DEATH <b>2:00 AM</b>	
4. SOCIAL SECURITY NUMBER <b>216-09-2981</b>		5. SEX <b>XX</b> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06 14 15</b>	
8. FACILITY NAME (If not institution, give street and number) <b>FROSTBURG HOSPITAL, INC</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>FROSTBURG</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>Md.</b>				10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Lonaconing</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>1 Buck Hill</b>			
10f. ZIP CODE <b>21539</b>				10g. CITIZEN OF WHAT COUNTRY? <b>US</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW 2</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Westvaco Employee</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Paper Manufacture</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William C. Schramm</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nancy E. Pierce</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Irene Schramm</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 Buck Hill, Lonaconing, Md. 21539</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. View Cemetery 2-25-94 Barton, Md.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Wayne Boal</b>				22. NAME AND ADDRESS OF FACILITY <b>Boal Funeral Home 111 Church St. Westernport, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Renal Failure</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>Consecutive Heart Failure</b> <b>Multiple Myeloma</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Charles H. H. MD</b>				29c. LICENSE NUMBER <b>D24951</b>		29d. DATE SIGNED (Month, Day, Year) <b>Feb 23, 94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>YANG, H. OH. MD. 48 TARN TERRACE, FROSTBURG, MD 21532</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 25 1994</b>				32. REGISTRAR'S SIGNATURE <b>John F. Anderson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 10M ROOM

21 10M ROOM

1000 1000 1000

1000 1000 1000



94 06795

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DOUGLAS MATTHEW SMITH				2. DATE OF DEATH MONTH DAY YEAR 2 22 1994		3. TIME OF DEATH 9:45 P M	
4. SOCIAL SECURITY NUMBER 579-20-8832		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 1, 1925	
9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE PA				10b. COUNTY Bedford		10c. CITY, TOWN OR LOCATION Artemas	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER Route 1 Box 57A		10f. ZIP CODE 17211	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) detective		16b. KIND OF BUSINESS/INDUSTRY police dept.	
17. FATHER'S NAME (First, Middle, Last) Douglas Wise Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Jane (nmn)			
19a. INFORMANT'S NAME (Type/Print) Elizabeth Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 1 Box 57A; Artemas, PA 17211			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematorium 2/24		20c. LOCATION — City or Town, State Smithsburg, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Liver Failure a. DUE TO (OR AS A CONSEQUENCE OF): b. Metastasis to Liver c. Carcinoma Colon d. Dehydration / Anorexia Approximate Interval Between Onset and Death 1 month 5/92 5/92							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER MO				29c. LICENSE NUMBER D 23371		29d. DATE SIGNED (Month, Day, Year) 2/23/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) QAMAR ZAMAN M.D., 625 KENT AVE., SUITE 102, CUMBERLAND, MD 21502							
31. DATE FILED (Month, Day, Year) FEB 25 1994				32. REGISTRAR'S SIGNATURE John D. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

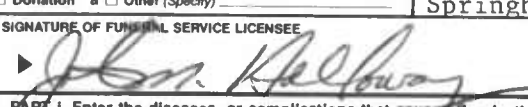
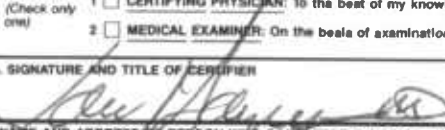
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CLARA MARIE SMITH				2. DATE OF DEATH MONTH DAY YEAR February 11, 1994		3. TIME OF DEATH 1:50 P M	
4. SOCIAL SECURITY NUMBER 214-10-8863		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 96 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 27, 1897	
8. BIRTHPLACE (State or Foreign Country) Wisconsin				9a. FACILITY NAME (If not institution, give street and number) 9502 Springhill Lane		9b. CITY, TOWN OR LOCATION OF DEATH Salisbury	
9c. COUNTY OF DEATH Wicomico				10a. STATE Maryland		10b. COUNTY Wicomico	
10c. CITY, TOWN OR LOCATION Salisbury				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 9502 Springhill Lane	
10f. ZIP CODE 21801				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		16b. KIND OF BUSINESS/INDUSTRY Garment	
17. FATHER'S NAME (First, Middle, Last) Ernest Amiel Yerkie				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha W. Boeck			
19a. INFORMANT'S NAME (Type/Print) Myrtle S. Bradley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9502 Springhill Lane, Salisbury, MD 21801			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Springhill Memory Gardens 2/14		20c. LOCATION — City or Town, State Hebron, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Coronary Arteriosclerosis</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 206844		29d. DATE SIGNED (Month, Day, Year) 2/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David J. Kellum MD 1304 South Division St, Salisbury, MD 21801							
31. DATE FILED (Month, Day, Year) FEB 17 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06797

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GEORGE DAWSON STEWART				2. DATE OF DEATH MONTH DAY YEAR February 9, 1994				3. TIME OF DEATH 0434 M	
4. SOCIAL SECURITY NUMBER 222-14-4518		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 30, 1927		8. BIRTHPLACE (State or Foreign Country) DELAWARE	
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY				9c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT									
10a. STATE DELAWARE		10b. COUNTY SUSSEX		10c. CITY, TOWN OR LOCATION SEAFORD				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 317 NYLON BLVD.				10f. ZIP CODE 19973		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12YRS. College (1-4 or 5+) 4YRS. +				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TEACHER			16b. KIND OF BUSINESS/INDUSTRY EDUCATION		
17. FATHER'S NAME (First, Middle, Last) GEORGE YOUNG STEWART				18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH BELLE DAWSON STEWART					
19a. INFORMANT'S NAME (Type/Print) DORIS F. STEWART				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 NYLON BLVD. SEAFORD, DELAWARE 19973					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) EASTERN SHORE CREMATORIUM 2/10/94			20c. LOCATION — City or Town, State GEORGETOWN, DELAWARE		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Samuel W. Yates</i>				22. NAME AND ADDRESS OF FACILITY WATSON-YATES FUNERAL HOME, INC. SEAFORD, DELAWARE 19973					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTISYSTEM ORGAN FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. PNEUMONIA / s/p mitral valve replacement DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Nicholas L. Ogburn MD</i>						29c. LICENSE NUMBER D34593		29d. DATE SIGNED (Month, Day, Year) 2/10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Nicholas Ogburn, MD. 25 Medical Center, Salisbury, MD. 21801									
31. DATE FILED (Month, Day, Year) FEB 18 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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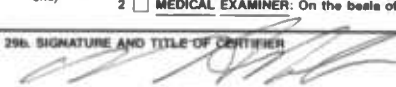
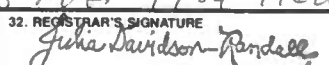
FOR THE DIRECTOR  
OF THE BUREAU OF  
LAND MANAGEMENT  
WASHINGTON, D.C.

FBI

94 06798

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>NELLIE S. SHEPPARD</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 16, 1994</b>		3. TIME OF DEATH <b>6:00 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>220-32-9232</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>100</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-9-1893</b>	
8. BIRTHPLACE (State or Foreign Country) <b>md.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Salisbury Nursing &amp; Rehab. Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>	
9c. COUNTY OF DEATH <b>Wicomico</b>				10a. STATE <b>MD.</b>		10b. COUNTY <b>WICOMICO</b>	
10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>PINE BLUFF VILLAGE</b>	
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PIANO INSTRUCTOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>MUSIC</b>	
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM E. SHEPPARD</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELLA SMITH</b>			
19a. INFORMANT'S NAME (Type/Print) <b>SALLY ADKINS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 4247 SALISBURY, MD. 21801</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PARSONS CEMETERY 2/21</b>		20c. LOCATION — City or Town, State <b>SALISBURY, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>BOUNDS FUNERAL HOME, SALISBURY, MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Dehydration</i> DUE TO (OR AS A CONSEQUENCE OF):							
b. <i>atherosclerotic disease</i> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>029549</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/7/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William Robins M.D. 1104 Healthway PR. Salisbury, MD</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 18 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HATTIE M. Stanley</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 18, 1994</b>		3. TIME OF DEATH <b>0140 A</b>	
4. SOCIAL SECURITY NUMBER <b>220-18-2640</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-15-1917</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD.</b>		10b. COUNTY <b>WICOMICO</b>		10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>700 SNOW HILL ROAD</b>				10f. ZIP CODE <b>21801</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PALMIST</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OWN BUSINESS</b>	
17. FATHER'S NAME (First, Middle, Last) <b>ANDREW MITCHELL</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LUCY ELLIOTT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JACK STANLEY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>700 SNOW HILL ROAD, SALISBURY, MD. 21801</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WICOMICO MEM. PARK 2/20 SALISBURY, MD.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>BOUNDS FUNERAL HOME, SALISBURY, MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>days</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>125679</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/18/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J A Cockey, 100 Power St., Salisbury, Md. 21801</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 18 1994</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) IVAR Ernest STRAND, SR				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 17, 1994				3. TIME OF DEATH 03:32 M			
4. SOCIAL SECURITY NUMBER 374-05-5035		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
9a. FACILITY NAME (If not institution, give street and number) CALVERT MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH PRINCE FREDERICK				9c. COUNTY OF DEATH CALVERT			
10a. STATE MD				10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION Huntingtown					
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 5111 Bay Parkway		10f. ZIP CODE 20639		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Administration		16b. KIND OF BUSINESS/INDUSTRY Social Security Adm.					
17. FATHER'S NAME (First, Middle, Last) John Ernest Strand				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna C. Fornell							
19a. INFORMANT'S NAME (Type/Print) Mary T. Strand				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5111 Bay Parkway Huntingtown, MD 20639							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St Pauls Epis. Ch. Cem 2-21-94		DATE 2-21-94		20c. LOCATION — City or Town, State Prince Frederick MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, P.A. Owings, MD							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Acute Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Coronary Artery Disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Diabetes mellitus</u> DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate interval Between Onset and Death 4 hours years years								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic Heart Failure</u>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER D38991		29d. DATE SIGNED (Month, Day, Year) February 17, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL DIARR MD 120 HOSPITAL ROAD, PRINCE FREDERICK MD 20638											
31. DATE FILED (Month, Day, Year) FEB 18, 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

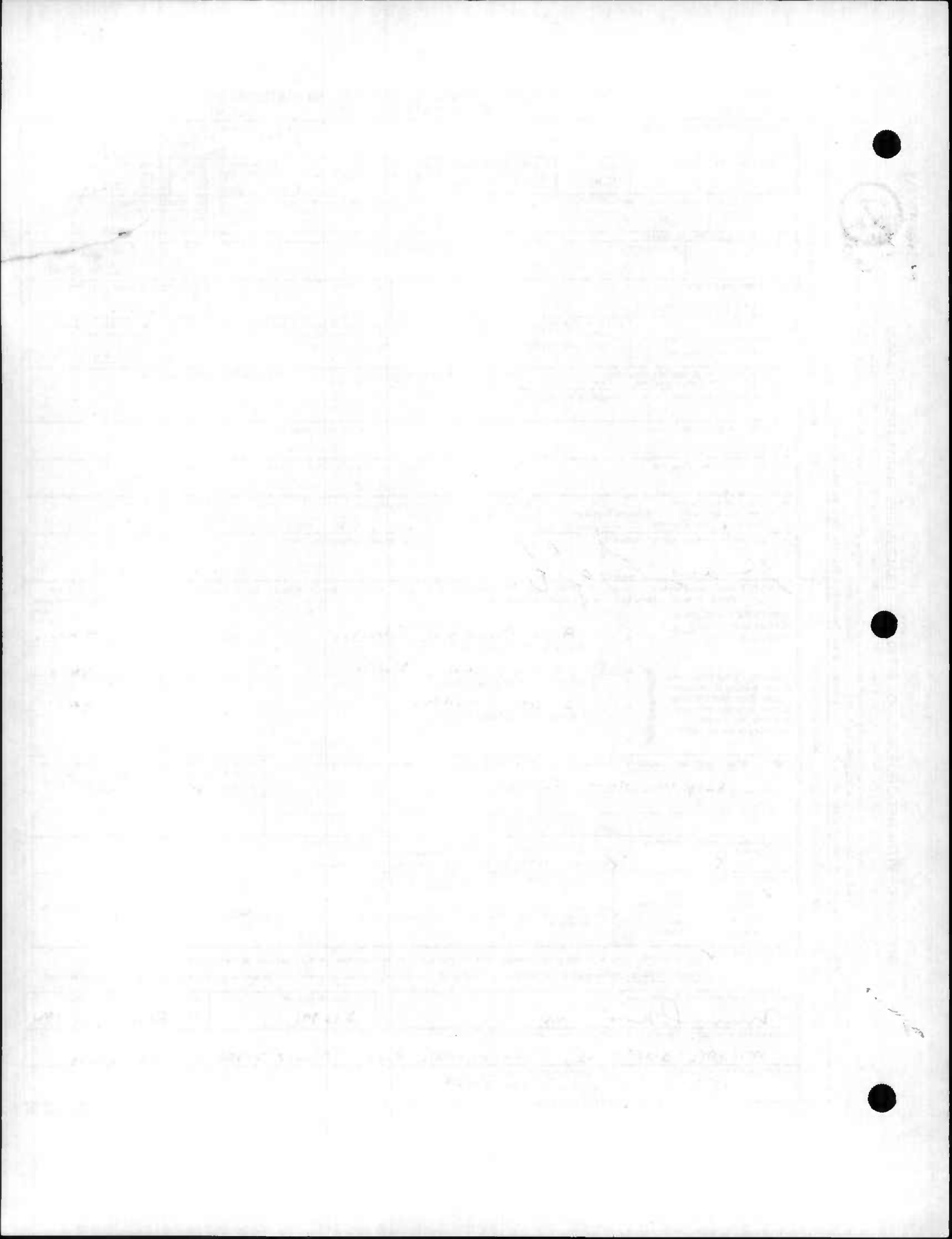
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

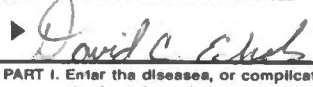


TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be retained by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MEGAN ANN SHERIDAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB. 21 94</b>		3. TIME OF DEATH <b>2:14 A<sup>M</sup></b>	
4. SOCIAL SECURITY NUMBER <b>218-35-2267</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>7</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-12-1986</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Charles</b>		10c. CITY, TOWN OR LOCATION <b>LaPlata</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>121 Wood Duck Circle</b>				10f. ZIP CODE <b>20646</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>1</b> College (1-4 or 5+) <b>1</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Student</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Elementary School</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Thomas M. Sheridan</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dawn Swann Sheridan</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dawn Sheridan</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>121 Wood Duck Circle LaPlata, MD 20646</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sacred Heart Cem. 2-24-94</b>		20c. LOCATION — City or Town, State <b>LaPlata, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>MO0945</b>		22. NAME AND ADDRESS OF FACILITY <b>AREHART-ECHOLS FUNERAL HOME, INC. LaPlata, MD 20646</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Blow to Head</b> DOE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>FEB. 20, 1994</b>		28b. TIME OF INJURY <b>12:20<sup>P</sup></b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <b>FIXED OBJECT PASSENGER IN AUTO/IMPACT</b>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>SOUTHBOWN-GLEN ARM ROAD GLEN ARM, BALTIMORE COUNTY</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB. 21, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Amerson 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ernest Richard Stevens, Sr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>02 17 1994</b>		3. TIME OF DEATH <b>12:45P</b>	
4. SOCIAL SECURITY NUMBER <b>229-22-5222</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>&amp; 70 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>08-03-1923</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Hartley Hall Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Pocomoke City</b>	
9c. COUNTY OF DEATH <b>Worcester</b>				10. RESIDENCE OF DECEDENT			
10a. STATE <b>Md.</b>		10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>Pocomoke City</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>723 Short Street</b>				10f. ZIP CODE <b>21851</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Poultry Plant</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Wilmer Stevens</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Claire Harmon</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Diane Hall</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1813 Pit Circle Pocomoke City, Md. 21851</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Trinity Cemetery</b>		20c. LOCATION — City or Town, State <b>Pocomoke City, Md.</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Savage Funeral Home P.O. Box 46 New Church, Va. 23415</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>CARCINOMA OF ESOPHAGUS WITH METASTASIS TO LUNG</b>					
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ANEMIA</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D 29505</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-18-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GREGORIO M. BELLOSO 4421 BEECHWOOD PLACE, CRISFIELD, MD 21817</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 through 4 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN MAYNARD (TYLER) Tyler				2. DATE OF DEATH MONTH DAY YEAR February 17 1994		3. TIME OF DEATH 1730 M	
4. SOCIAL SECURITY NUMBER 218-16-9610		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 2, 1920	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE Maryland		10b. COUNTY Somerset	
10c. CITY, TOWN OR LOCATION Crisfield				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 3175 Boone Road	
10f. ZIP CODE 21817				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W. W. II- U. S. Army				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Grade 7 - - -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Processor		16b. KIND OF BUSINESS/INDUSTRY Seafood	
17. FATHER'S NAME (First, Middle, Last) Maynard Tyler				18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Owens			
19a. INFORMANT'S NAME (Type/Print) Peggy L. Tyler (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3175 Boone Rd. - Crisfield, MD 21817			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Asbury Cemetery 02-20-94		20c. LOCATION — City or Town, State Crisfield, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert H. Bradshaw, Jr.				22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident 4 days Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Intracerebral Hemorrhage 4 days c. Essential Hypertension 10 years d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertensive Heart Disease Basal cell Ca Forehead							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER George L. Evangelista				29c. LICENSE NUMBER 73-7670		29d. DATE SIGNED (Month, Day, Year) 2/19/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. L. M. Evangelista				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 105 Pine Bluff Rd #8 Salisbury, MD 21801			
31. DATE FILED (Month, Day, Year) FEB 24 '94				31. REGISTRAR'S SIGNATURE John D. Anderson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

REVENUE BOARD

NO. 100-100000

DEPT. OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D.C. 20250

W. H. H. H. H.

THE BOARD OF LAND MANAGEMENT  
HAS THE HONOR TO ACKNOWLEDGE  
THE RECEIPT OF THE FOLLOWING

THE FOLLOWING IS A LIST OF THE

FEB 10 1960  
BUREAU OF LAND MANAGEMENT

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EDITH V THOMPSON</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>14</b> YEAR <b>94</b>		3. TIME OF DEATH <b>4:00 A.M.</b>							
4. SOCIAL SECURITY NUMBER <b>214-14-7695</b>		5. SEX <b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>76</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>8-18-1918</b>		8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>FROSTBURG HOSPITAL, INC</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>FROSTBURG</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>							
RESIDENCE OF DECEDENT													
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Frostburg</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>81 East Mechanic St. Apt. 108</b>				10f. ZIP CODE <b>21532</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>									
17. FATHER'S NAME (First, Middle, Last) <b>UNKNOWN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>UNKNOWN</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Peggy Wigfield</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15 Vancouver St. Cumberland, Md. 21502</b>									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Resthaven Mem. Gardens 2-15-94</b>		20c. LOCATION — City or Town, State <b>Frederick, Maryland</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ernest A. Riley, Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>Leasure-Stein, Inc. 230 Baltimore Av. Cumberland, Md. 21502</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Massive CVA</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <table border="0"> <tr> <td>b. <b>Complete Heart Block s/p Pacemaker</b></td> <td>1 yr</td> </tr> <tr> <td>c. <b>ABCD - Hypertension</b></td> <td>20 yrs</td> </tr> <tr> <td>d. <b>Diabetes mellitus</b></td> <td>20 yrs</td> </tr> </table>							b. <b>Complete Heart Block s/p Pacemaker</b>	1 yr	c. <b>ABCD - Hypertension</b>	20 yrs	d. <b>Diabetes mellitus</b>	20 yrs	Approximate Interval Between Onset and Death <b>Miss</b>
b. <b>Complete Heart Block s/p Pacemaker</b>	1 yr												
c. <b>ABCD - Hypertension</b>	20 yrs												
d. <b>Diabetes mellitus</b>	20 yrs												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED									
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Angel H Roque</b>				29c. LICENSE NUMBER <b>013166</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/14/94</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR ANGEL H ROQUE 48 TARN TERRACE, FROSTBURG, MD 21532</b>													
31. DATE FILED (Month, Day, Year) <b>FEB 17 1994</b>				32. REGISTRAR'S SIGNATURE <b>John D. ...</b>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE VETERAN BOARD  
OF THE UNITED STATES  
DEPARTMENT OF VETERANS AFFAIRS  
WASHINGTON, D.C. 20330

MEMORANDUM FOR THE RECORD

SUBJECT: [Illegible]

DATE: [Illegible]

BY: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Clay Edward Thomas				2. DATE OF DEATH MONTH 2 DAY 19 YEAR 94		3. TIME OF DEATH 1:51PM M	
4. SOCIAL SECURITY NUMBER 215-34-4878		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6/5/39	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
10a. STATE Maryland				10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 315 Caroline STREET		10f. ZIP CODE 21532	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES VIETNAM	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12+2 College (1-4 or 5+) College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) U.S. MARINE CORP				16b. KIND OF BUSINESS/INDUSTRY FINGER PRINT EXPERT			
17. FATHER'S NAME (First, Middle, Last) LEONARD WAYNE THOMAS				18. MOTHER'S NAME (First, Middle, Maiden Surname) MABEL MARGARET KELLY			
19a. INFORMANT'S NAME (Type/Print) BEVERLY ANN THOMAS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 CAROLINE STREET CUMBERLAND MARYLAND 21502			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DAVIS CEMETERY FEB 23 1994		20c. LOCATION — City or Town, State cumberland maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Paul L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. Self inflicted gun shot wound to the chest							
DUE TO (OR AS A CONSEQUENCE OF):							
Post traumatic stress depression							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 2/19/94		28b. TIME OF INJURY ard Noon	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED self inf gun shot wound chst			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) residence				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 315 Caroline St Cumb Md 21502			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Snow</i> Dpty Med Ex				29c. LICENSE NUMBER D 01957		29d. DATE SIGNED (Month, Day, Year) 2/19/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Snow, M.D. 124 w. 3rd st Cumb Md 21502							
31. DATE FILED (Month, Day, Year) FEB 22 1994				32. REGISTRAR'S SIGNATURE <i>John D. Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Minnie S. Thomas				2. DATE OF DEATH MONTH 2 DAY 18 YEAR 94		3. TIME OF DEATH 4:20 PM	
4. SOCIAL SECURITY NUMBER 214 07 5480		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 3/10/12	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) Frostburg Hospital, Inc		9b. CITY, TOWN OR LOCATION OF DEATH Frostburg	
9c. COUNTY OF DEATH Allegany				10a. STATE MARYLAND		10b. COUNTY ALLEGANY	
10c. CITY, TOWN OR LOCATION FROSTBURG				10d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10e. STREET AND NUMBER 16922 MONTEL ROAD	
10f. ZIP CODE 21532				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 4 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SPINDLE MACHINE OPERATOR		16b. KIND OF BUSINESS/INDUSTRY CELANESE CORP.	
17. FATHER'S NAME (First, Middle, Last) WILLIAM SHEARER				18. MOTHER'S NAME (First, Middle, Maiden Surname) GERTRUDE BRENDLEN			
19a. INFORMANT'S NAME (Type/Print) ROBERT STAUP				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16922 MONTEL ROAD, FROSTBURG, MD 21532			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) VALE SUMMIT METHODIST CEM 2/20		20c. LOCATION — City or Town, State VALE SUMMIT, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Marilyn M. Sowers</i>				22. NAME AND ADDRESS OF FACILITY SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>CHF II E.</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>ASHD - diabetes</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Renal failure</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>old stroke</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOR OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John N. Mehan</i>				29c. LICENSE NUMBER D-17526		29d. DATE SIGNED (Month, Day, Year) 2-21-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN N. MEHANNA, M.D. 909B Seton drive - Cumberland, Md. 21502							
31. DATE FILED (Month, Day, Year) FEB 23 1994				32. REGISTRAR'S SIGNATURE <i>John N. Mehan</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1901



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L.R.B.

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ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-709 3/9/94 t.t.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SPENCER E. TAYLOR</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB 18 1994</b>		3. TIME OF DEATH <b>6:15P</b>	
4. SOCIAL SECURITY NUMBER <b>218-84-6764</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>20</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 1, 1973</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>MATTAWOMEN CREEK</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>INDIAN HEAD</b>	
9c. COUNTY OF DEATH <b>CHARLES</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>CHARLES</b>	
10c. CITY, TOWN OR LOCATION <b>WALDORF</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>3399 RYAN COURT</b>	
10f. ZIP CODE <b>20601</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9TH GRADE</b> College (1-4 or 5+) <b>UNEMPLOYED</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>		16b. KIND OF BUSINESS/INDUSTRY <b>NONE</b>	
17. FATHER'S NAME (First, Middle, Last) <b>SPENCER EUGENE JOHNSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY E. TAYLOR JOHNSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARY E. JOHNSON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3399 RYAN COURT, WALDORF, MARYLAND 20601</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HARMONY MEMORIAL PARK 2/24/94</b>		20c. LOCATION — City or Town, State <b>HYATTSVILLE, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lidia C. Thornton Johnson</i> <b>LIDIA C. THORNTON JOHNSON MO0583</b>				22. NAME AND ADDRESS OF FACILITY <b>THORNTON FUNERAL HOME, P.A. POMONKEY, MARYLAND 20640</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DROWNING</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>CREEK</b>				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year) <b>FOUND: 2-18-94</b>				28b. TIME OF INJURY <b>4:22 P M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>FOUND: MATTAWOMEN CREEK</b>				28e. DESCRIBE HOW INJURY OCCURED <b>SUBJECT DROWNED</b>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>WALDORF, MARYLAND</b>				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Laron Locke MD</i> <b>LARON LOCKE MD</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB 19 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>LARON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201.</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 24 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MAGGIE ELIZABETH TIMMONS			2. DATE OF DEATH MONTH DAY YEAR Feb 11 1994		3. TIME OF DEATH 6:00 P M						
4. SOCIAL SECURITY NUMBER 217-01-8694		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 30, 1903		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Salisbury Nursing & Rehab Center				9b. CITY, TOWN OR LOCATION OF DEATH Salisbury, Md.		9c. COUNTY OF DEATH Wicomico					
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Powellville			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER Easy St.				10f. ZIP CODE 21852		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 0			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress			16b. KIND OF BUSINESS/INDUSTRY Shirt factory					
17. FATHER'S NAME (First, Middle, Last) Sewell (unk) Davis					18. MOTHER'S NAME (First, Middle, Maiden Surname) Lizzie (unk) Smith						
19a. INFORMANT'S NAME (Type/Print) Louise T. Davis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4657 Elmer Davis Loop, Pittsville, MD 21850							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Powellville Cemetery			DATE 2/14		20c. LOCATION — City or Town, State Powellville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Holloway</i>				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Diabetes</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. e. Approximate Interval Between Onset and Death 15 yrs 15 yrs											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William Robins, Jr.</i>					29c. LICENSE NUMBER P-29349		29d. DATE SIGNED (Month, Day, Year) 2/14/94				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William Robins, Jr. 1104 HEALTHWAY DRIVE, SALISBURY, Md. 21801											
31. DATE FILED (Month, Day, Year) FEB 17 1994			32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06809

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>William Thomas Van Meter</u>				2. DATE OF DEATH MONTH DAY YEAR <u>Feb 16 1994</u>		3. TIME OF DEATH <u>2335</u> M	
4. SOCIAL SECURITY NUMBER <u>236 03 4392</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>76</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Sept 6 1917</u>	
8. BIRTHPLACE (State or Foreign Country) <u>W.Va</u>				9. FACILITY NAME (If not institution, give street and number) <u>Garrett Co. Mem. Hospital</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Oakland</u>	
9c. COUNTY OF DEATH <u>Garrett</u>				10a. STATE <u>W.Va</u>		10b. COUNTY <u>Mineral</u>	
10c. CITY, TOWN OR LOCATION <u>Elk Garden</u>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <u>Rt 1 Box 265</u>	
10f. ZIP CODE <u>26717</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>UNK</u> College (1-4 or 5+) <u></u>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Coal Miner</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Coal</u>			
17. FATHER'S NAME (First, Middle, Last) <u>William Van Meter</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Minnie Rohrbaugh</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Sharon Paugh</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Rt1 Box 265 Elk Garden, W.Va. 26717</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Kalbaugh Cemetery 2+20 94 Elk Garden W.Va</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>David A. Burdock</u>				22. NAME AND ADDRESS OF FACILITY <u>David A. Burdock FH PO Box 523 Kitzmiller, Md 21538</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Renal Failure</u> Approximate Interval Between Onset and Death <u>6 weeks</u>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <u>diabetes mellitus</u> years							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HBP</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)			
28b. TIME OF INJURY M				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Hobbs</u>				29c. LICENSE NUMBER <u>D15333</u>			
29d. DATE SIGNED (Month, Day, Year) <u>1/18/94</u>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)			
31. DATE FILED (Month, Day, Year) <u>FEB 22 1994</u>				32. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


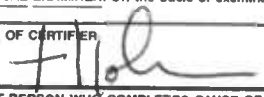

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06810

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LUCILLE ELIZABETH WILSON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 15, 1994</b>		3. TIME OF DEATH <b>10:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>212-54-8705</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 14, 1909</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Garrett Co. Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Oakland</b>	
9c. COUNTY OF DEATH <b>Garrett</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Garrett</b>	
10c. CITY, TOWN OR LOCATION <b>Mt. Lake Park</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>300 D Street</b>	
10f. ZIP CODE <b>21550</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>David K. Glaze</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Etta Wright</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jean Fafrak</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>300 D Street Mt. Lake Park, Md. 21550</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrett Memorial Gardens 2/18</b>			
20c. LOCATION — City or Town, State <b>Oakland, Maryland</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00167			
22. NAME AND ADDRESS OF FACILITY <b>P.O. Box 243 Durst Funeral Home - Oakland, Md. 21550</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>CVA</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>high blood pressure</b> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>5 days</b> <b>years</b> <b>years</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ovarian CA</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>			
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 			
29c. LICENSE NUMBER <b>D15333</b>				29d. DATE SIGNED (Month, Day, Year) <b>2/16/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Thomas G. Johnson, M.D. 311 N. Fourth St. Oakland, Md. 21550</b>				31. DATE FILED (Month, Day, Year) <b>FEB 17 1994</b>			
32. REGISTRAR'S SIGNATURE 							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION








94 06811

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EVELYN M WINEBRENNER</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>09</b> YEAR <b>94</b>		3. TIME OF DEATH <b>2:15AM</b> M	
4. SOCIAL SECURITY NUMBER <b>215-76-2673</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH <b>08-25-24</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Garrett</b>		10c. CITY, TOWN OR LOCATION <b>Frostburg (Rural Garrett Co.)</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Star Route, Box 10, National Pike</b>				10f. ZIP CODE <b>21532</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Norman Garlitz</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rhoda Robison</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Connie S. House</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt. 2, Box 124, Friendsville, MD 21531</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery 2-11</b>		20c. LOCATION — City or Town, State <b>Frostburg, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Newman Funeral Homes, P.A. 155 Main St., Grantsville, MD 21536</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Pneumonia</b>  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus, Leukopenia</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>MD 35735</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/9/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Thomas E. Chapman MD 912 Selma Dr Cumberland MD</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 16 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06812

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Hyland Franklin				2. DATE OF DEATH MONTH DAY YEAR 2 10 94		3. TIME OF DEATH 4:20 AM	
4. SOCIAL SECURITY NUMBER 215-12-6319		5. SEX XX M 2 F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-7-1921	
9a. FACILITY NAME (If not institution, give street and number) Wesleyan Health Care Center				9b. CITY, TOWN OR LOCATION OF DEATH Denton		9c. COUNTY OF DEATH Caroline	
10a. STATE Delaware				10b. COUNTY Kent		10c. CITY, TOWN OR LOCATION Harrington, Delaware	
10d. INSIDE CITY LIMITS? 1 YES 2 X NO				10e. STREET AND NUMBER R.D.# 3, Box 27			
10f. ZIP CODE 19952				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervision Permit & Utility		16b. KIND OF BUSINESS/INDUSTRY State of Delaware			
17. FATHER'S NAME (First, Middle, Last) Montilles Johnson Webb				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie (Wharton) Webb			
19a. INFORMANT'S NAME (Type/Print) Anna Webb				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) R.D.# 3, Box 27, Harrington, DE			
20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hollywood Cemetery		20c. LOCATION — City or Town, State Harrington, DE		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE X Thomas E. Melvin				22. NAME AND ADDRESS OF FACILITY Melvin F.H. P.O. Box 203, Harrington, DE 19932			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis - Urinary obstruction DUE TO (OR AS A CONSEQUENCE OF): b. Death DUE TO (OR AS A CONSEQUENCE OF): c. Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 48 hrs 72 hrs 5 yrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 X NO
27. MANNER OF DEATH 1 X Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 X NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Henry DiTommaso				29c. LICENSE NUMBER H00058		29d. DATE SIGNED (Month, Day, Year) 2-16-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr Henry DiTommaso CHS P.O. Box 122 Goldsboro MD 21636							
31. DATE FILED (Month, Day, Year) FEB 16 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ruth Lula WHITE				2. DATE OF DEATH MONTH DAY YEAR February 13, 1994		3. TIME OF DEATH 6:50 P M	
4. SOCIAL SECURITY NUMBER 233-52-8506		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4/1/1910	
8. BIRTHPLACE (State or Foreign Country) Grant Co., WV				9a. FACILITY NAME (If not institution, give street and number) Dennett Road Manor Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Oakland	
9c. COUNTY OF DEATH Garrett				10a. STATE WV			
10b. COUNTY Preston				10c. CITY, TOWN OR LOCATION Terra Alta			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER Rt. 1, Box 7			
10f. ZIP CODE 26764				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cook		16b. KIND OF BUSINESS/INDUSTRY State Hospital	
17. FATHER'S NAME (First, Middle, Last) James William Mahaffey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora Frances Cosner			
19a. INFORMANT'S NAME (Type/Print) Freda B.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Brighton Drive, Clarksburg, WV 26301			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Terra Alta Cemetery		20c. DATE 2/16		20d. LOCATION — City or Town, State Terra Alta, West Va.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Bridget D. Dwyer</i>				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, Md 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Stroke, acute coronary heart disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>COPD</i> <i>Legion</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Robert Coughlin</i>				29c. LICENSE NUMBER D33464		29d. DATE SIGNED (Month, Day, Year) 2/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Robert Coughlin, MD P.O. Box 8, Eggleston, WV 26716							
31. DATE FILED (Month, Day, Year) FEB 16 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

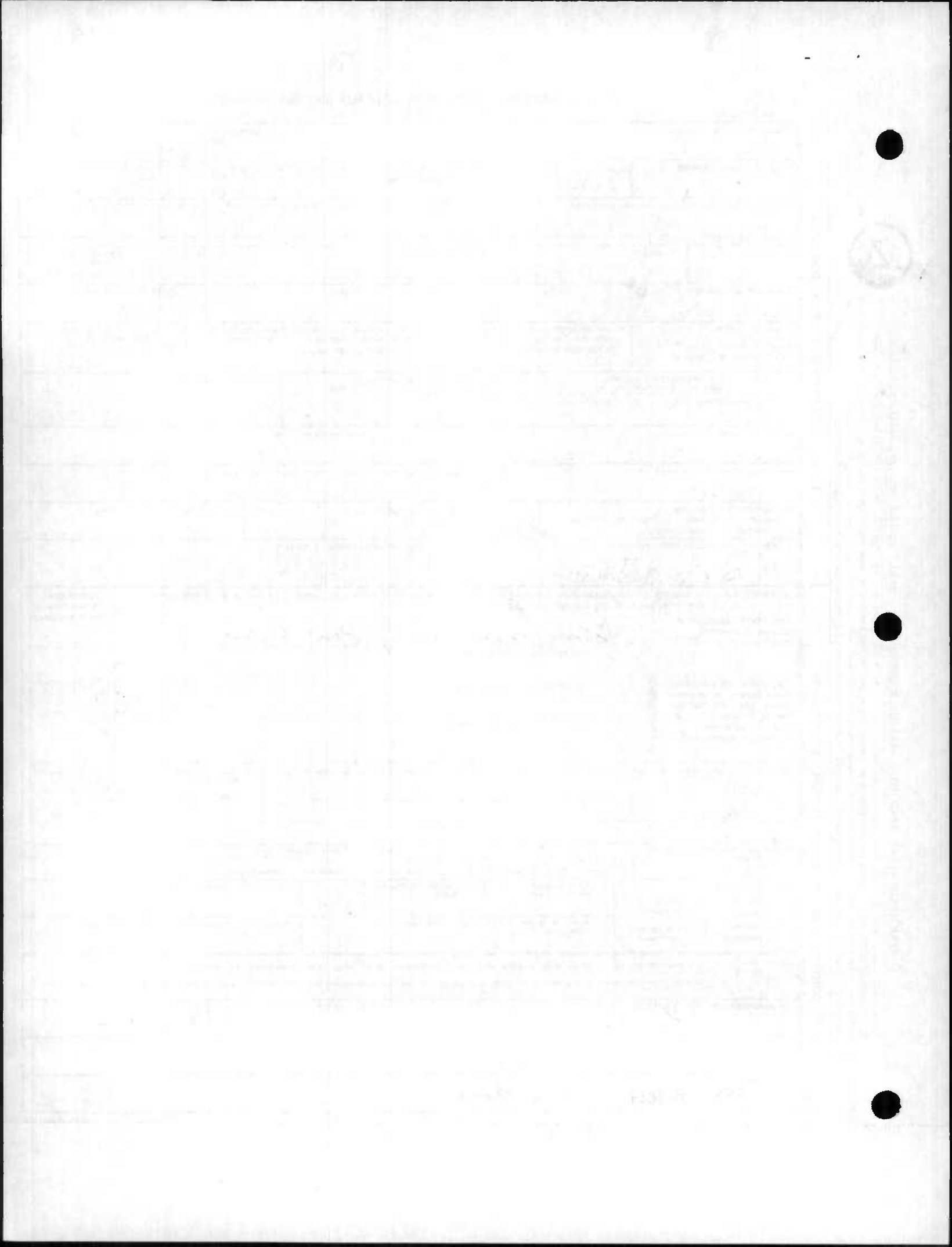
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CLARA Mae WINTERS				2. DATE OF DEATH MONTH DAY YEAR February 9, 1994		3. TIME OF DEATH 6:47 P M	
4. SOCIAL SECURITY NUMBER 236-20-9498		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 22, 1921	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital & Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
10a. STATE WV				10b. COUNTY Mineral		10c. CITY, TOWN OR LOCATION Keyser	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 1555 Terri Street			
10f. ZIP CODE 26726				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11th.				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Guy Jacob Trenton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Stonebeaker			
19a. INFORMANT'S NAME (Type/Print) Murray C. Winters				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1555 Terri Street, Apt. 1, Keyser, WV 26726			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Queens Point Cemetery 2/15/94		20c. LOCATION — City or Town, State Keyser, West Virginia		20d. DATE 2/15/94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Harold Dean Nofziger				22. NAME AND ADDRESS OF FACILITY Markwood McKenzie Funeral Home, Inc. 111 S. Mineral St., Keyser, WV 26726			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → NEUROLOGIC a. PNEUMONIA - COMMUNITY ACQUIRED b. LUNG ABCESS WITH c. EMPHYSEMA d. RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 MECH VENTILATION ATELECTASIS & NEUROLOGIC LUNG, CVA - BRAIN STEM							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER James M. D.				29c. LICENSE NUMBER D 18769		29d. DATE SIGNED (Month, Day, Year) 2/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James M. D., Memorial Hospital Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) FEB 17 1994				32. REGISTRAR'S SIGNATURE John Benson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. The funeral director must complete and file the certificate with the State Department of Health and Mental Hygiene within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NORMAN Martin WELTY				2. DATE OF DEATH MONTH DAY YEAR February 20, 1994		3. TIME OF DEATH 7:14 A M	
4. SOCIAL SECURITY NUMBER 214-16-0803		5. SEX XX M 2 F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-13-1914	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital & Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland	
9c. COUNTY OF DEATH Allegany				10a. STATE Maryland		10b. COUNTY Allegany	
10c. CITY, TOWN OR LOCATION Cumberland				10d. INSIDE CITY LIMITS? 1 X YES 2 NO		10e. STREET AND NUMBER J.F.K. Homes 135 N. Mechanic St.	
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Construction		16b. KIND OF BUSINESS/INDUSTRY George Con. Co.	
17. FATHER'S NAME (First, Middle, Last) Luther Welty				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nonie Palmer			
19a. INFORMANT'S NAME (Type/Print) Marion Welty				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10e			
20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Zion Mem. Park 2-22-94		20c. LOCATION — City or Town, State Cumberland, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ernest A. R. J. H.				22. NAME AND ADDRESS OF FACILITY Leasure-Stein, Inc. 230 Baltimore Av. Cumberland, Md. 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiorespiratory Arrest Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Subarachnoid CHF AD ASCVD PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. MANNER OF DEATH 1 X Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 YES 2 NO	
28c. INJURY AT WORK? 1 YES 2 NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Terry Williams MD				29c. LICENSE NUMBER D16041		29d. DATE SIGNED (Month, Day, Year) 2-21-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Terry Williams Memorial Hospital Medical Building Cumberland, MD. 21502							
31. DATE FILED (Month, Day, Year) FEB 22 1994				32. REGISTRAR'S SIGNATURE John Benson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Paula Marie Walker</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 20, 1994</b>		3. TIME OF DEATH <b>10:35 p. M</b>	
4. SOCIAL SECURITY NUMBER <b>324-26-0753</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jul 5, 1907</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Frostburg Village Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frostburg</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>crn Baltimore &amp; Liberty Sts.</b>			
10f. ZIP CODE <b>21502</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>own home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Rev. Harry Porter</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Babcock</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Shirley A Giarritta</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>55 N. Centre Street Cumberland MD 21502</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Smithsburg Crematorium 2/21/ Smithsburg MD</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, Maryland 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Massive Pneumonia</b> Due to (or as a consequence of): <b>Aspiration</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Alzheimer's Disease</b> <b>Arteriosclerosis</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>S.L. Sandhir MD</b>				29c. LICENSE NUMBER <b>D14464</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/21/1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. S.L. Sandhir; 48 Tarn Terrace, Frostburg, MD 21532</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>				32. REGISTRAR'S SIGNATURE <b>John H. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ungratified

NEPT 87

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RICHARD FRANKLIN WEESE SR.				2. DATE OF DEATH MONTH DAY YEAR 02 22 94		3. TIME OF DEATH 14:45 p M	
4. SOCIAL SECURITY NUMBER 236-48-3363		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT 7 1932	
9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL & MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND, MARYLAND		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE W. VA.				10b. COUNTY MINERAL		10c. CITY, TOWN OR LOCATION RIDGELEY	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER RFD#2 BOX#503			
10f. ZIP CODE 26753				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) KELLY SPRINGFIELD TIRE CO.		16b. KIND OF BUSINESS/INDUSTRY MANUF. TIRES			
17. FATHER'S NAME (First, Middle, Last) ELMER WILLIAM WEESE				18. MOTHER'S NAME (First, Middle, Maiden Surname) DOROTHY ALMEDA REXRODE			
19a. INFORMANT'S NAME (Type/Print) HAZEL WEESE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RFD#2 BOX#503 RIDGELEY, W.VA. 26753			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FORT ASHBY CEMETERY FEB 25 1994		20c. LOCATION — City or Town, State FORT ASHBY W.VA.		20d. DATE FEB 25 1994	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Myocardial Infarction</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus</i> <i>Cardiogenic shock</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D 14865		29d. DATE SIGNED (Month, Day, Year) 2-23-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. ROBUSTIANO BARRERA, MEMORIAL HOSPITAL MEDICAL BLDG., CUMBERLAND, MD 21502							
31. DATE FILED (Month, Day, Year) FEB 24 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06818

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LEAFY MABEL		2. DATE OF DEATH MONTH FEBRUARY DAY 23, YEAR 1994		3. TIME OF DEATH 3:10 A M
4. SOCIAL SECURITY NUMBER 212-12-8800	5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 84 YRS.	7. DATE OF BIRTH (Month, Day, Year) MARCH 16 1909	8. BIRTHPLACE (State or Foreign Country) MARYLAND
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital & Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CUMBERLAND
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1522B OLDTOWNE MANOR		
10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+)		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FORD'S DRUG STORE		16b. KIND OF BUSINESS/INDUSTRY RETAIL CLERK		
17. FATHER'S NAME (First, Middle, Last) GEORGE C. SMITH		18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH ELMA ROTH		
19a. INFORMANT'S NAME (Type/Print) DONALD E. DeHAVEN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2310 SIBLEY STREET ALEXANDRIA, VA. 22311		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) RED HOUSE LUTH. CEMETERY FEB 26 1994		20c. LOCATION — City or Town, State RED HOUSE MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>		22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>urosepsis; Dehydration</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Anorexia; Malnutrition</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>pulmonary Emboli</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Cerebrovascular Accident</i>				Approximate interval Between Onset and Death <i>1 wch</i> <i>1 wch</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER D23371		29d. DATE SIGNED (Month, Day, Year) <i>2/23/94</i>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Zaman Johnson Heights Medical Building Cumberland, MD. 21502				
31. DATE FILED (Month, Day, Year) FEB 24 1994		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 4 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Michele Ann Wahler				2. DATE OF DEATH MONTH DAY YEAR February 20 1994		3. TIME OF DEATH 04:26 A: M	
4. SOCIAL SECURITY NUMBER 578-70-9232		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 42 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 13, 1952	
9a. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH LaPlata		9c. COUNTY OF DEATH Charles	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION Waldorf		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4022 Posey Ct.				10f. ZIP CODE 20602		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesperson		16b. KIND OF BUSINESS/INDUSTRY Advertising			
17. FATHER'S NAME (First, Middle, Last) David H. Meteyer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Theodora Mills			
19a. INFORMANT'S NAME (Type/Print) John L. Wahler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4022 Posey ct., Waldorf, MD 20602			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Trinity Memorial Gardens		DATE 2-24		20c. LOCATION — City or Town, State Waldorf, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Benjamin Matthews M000658				22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604-0156			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? (Check only one) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  Howard M. Haft MD				29c. LICENSE NUMBER D-27348		29d. DATE SIGNED (Month, Day, Year) 2/20/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Howard M. Haft MD P.O. Box 1647 Waldorf, Md 20604							
31. DATE FILED (Month, Day, Year) FEB 24 1994		32. REGISTRAR'S SIGNATURE  Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 7, 8, 9 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY E. WALTERS</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>15</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>7:15P.M</b>	
4. SOCIAL SECURITY NUMBER <b>212-05-0142</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-9-1909</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>MANOKIN MANOR</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>PRINCESS ANNE</b>		9c. COUNTY OF DEATH <b>SOMERSET</b>	
10a. STATE <b>MD.</b>				10b. COUNTY <b>WICOMICO</b>		10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>501 EMORY COURT, APT. # 203</b>				10f. ZIP CODE <b>21801</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>C &amp; P TELEPHONE</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SUPERVISER</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM L. SHORES</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EVA CULLISON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MILTON L. ELGIN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>32708 994 SLEEPING ROCK CT., WINTER SPRINGS, FLA.</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>EASTERN SHORE CREM. 2-16 GEORGETOWN, DEL.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>BOUNDS FUNERAL HOME, SALISBURY, MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>7 days</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Urinary tract infection</b> <b>Organic Brain Syndrome</b> <b>Senile Dementia</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>P37670</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/16/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. L. M. Evangeliste</b> <b>105 Pine Bluff Rd #4 Salisbury, MD 21801</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 17 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Louise W. West				2. DATE OF DEATH MONTH DAY YEAR February 17 94		3. TIME OF DEATH 0950 M	
4. SOCIAL SECURITY NUMBER 214-12-6262D		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 7, 1906	
8. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER Rt. 50 & Civic Ave.				10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 8+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) William Dedray Wroten				18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Wilhelmina Helmker Wroten			
19a. INFORMANT'S NAME (Type/Print) Douglas West				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3925 Green Hill Church Road Quantico, Md 21856			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Perryhawkin Cemetery		DATE 2-19		20c. LOCATION — City or Town, State Princess Anne, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William M. Short</i>				22. NAME AND ADDRESS OF FACILITY Short Funeral Home 13 E. Grove St. Delmar, DE 19940			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Probable Acute MI w/ total</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>CARDIAC ARREST</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>minutes</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ALZHEIMER'S DISEASE</i> <i>ATRIAL FIBRILLATION</i> <i>UICAN GIBBON</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Atkins</i>				29c. LICENSE NUMBER D-39813		29d. DATE SIGNED (Month, Day, Year) 2/18/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael Atkins, 1104 Heathway Drive, Salisbury, MD 21801							
31. DATE FILED (Month, Day, Year) FEB 22 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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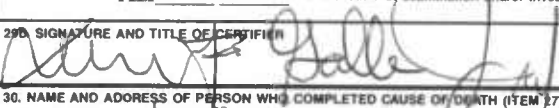
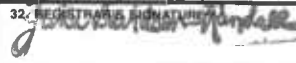
94 06822

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ITEMS: 23 PART I, 27, PER MEO FILM G-709 3/7/94 t.t.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MICHAEL W. WARRICK</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB 21 1994</b>		3. TIME OF DEATH <b>7:15 A M</b>	
4. SOCIAL SECURITY NUMBER <b>212-70-0669</b>		5. SEX <b>1 M 2 F</b>		8. AGE (In yrs. last birthday) <b>36</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 17, 1957</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>216 S. BOHEMIA AVE APT#4</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>CHESAPEAKE CITY</b>		9c. COUNTY OF DEATH <b>CECIL</b>			
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Cecil</b>		10c. CITY, TOWN OR LOCATION <b>Chesapeake City</b>		10d. INSIDE CITY LIMITS? <b>1 X YES 2 NO</b>	
10e. STREET AND NUMBER <b>216 Bohemia Avenue</b>				10f. ZIP CODE <b>21915</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <b>1 X Never Married 2 Married</b> <b>3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 X NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 X NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>11</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Stephen S. Warrick</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Roseleen D. Jordan</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Roseleen D. Warrick</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>150 West Columbia Street - Hempstead, NY 11550</b>			
20a. METHOD OF DISPOSITION <b>1 X Burial 2 Cremation 3 Removal from State</b> <b>4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Bohemia Manor Cemetery 2/25/94</b>		20c. LOCATION — City or Town, State <b>Chesapeake City, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CIRRHOSIS OF THE LIVER</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <b>1 X YES 2 NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 X YES 2 NO</b>		28. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 X Residence 6 Other (Specify)</b>					
27. MANNER OF DEATH <b>1 X Natural 5 Pending Investigation</b> <b>2 Accident 3 Suicide 4 Homicide</b> <b>6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB 22, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLIS JR MD 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 06823

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Barbara Peacock Wright</b>				2. DATE OF DEATH MONTH DAY YEAR <b>02 11 1994</b>		3. TIME OF DEATH <b>11:40 p M</b>	
4. SOCIAL SECURITY NUMBER <b>214-32-6223</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>56</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>07/28/1937</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>709 Homewood Drive</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Pocomoke City</b>	
9c. COUNTY OF DEATH <b>Worcester</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Worcester</b>	
10c. CITY, TOWN OR LOCATION <b>Pocomoke City</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>709 Homewood Drive</b>	
10f. ZIP CODE <b>21851</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker &amp; Model</b>				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Merritt Jackson Peacock</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ethel Darr Stone</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Daryl Lance Wright</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>709 Homewood Dr., Pocomoke City, Md. 21851</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Salem Methodist Cemetery 12/16 Pocomoke City, Md.</b>			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Scott S. Melson</b>			
22. NAME AND ADDRESS OF FACILITY <b>Melson Funeral Home PO BOX 64, Pocomoke, Md. 21851</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Carcinoma of Lung</b> <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>J. E. Martin, M.D.</b>			
29c. LICENSE NUMBER <b>030690</b>				29d. DATE SIGNED (Month, Day, Year) <b>2/16/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James E. Martin, M.D., 145 E. Carroll St., Salisbury, Md.</b>				31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>			
32. REGISTRAR'S SIGNATURE <b>Julius Benjamin Ruckelshaus</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1875-1876

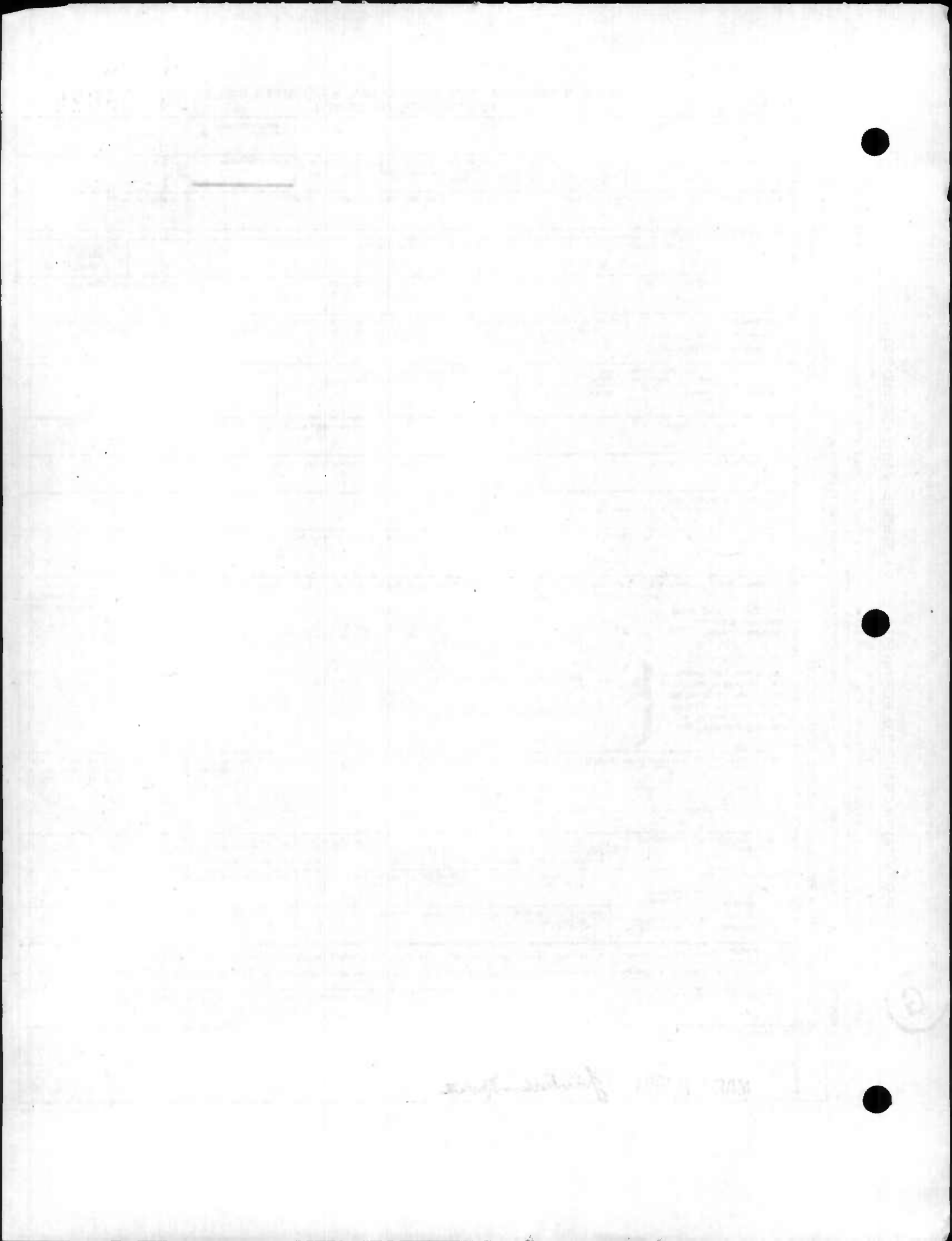
HYGIENE 94 06824  
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \_\_\_\_\_ hours after death. Page 6 may be retained by the hospital or attending physician.

**IMPORTANT:** If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last) <b>SAMUEL ACREE</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>05</b> YEAR <b>94</b>				3. TIME OF DEATH <b>5:30 A M</b>							
4. SOCIAL SECURITY NUMBER <b>216-20-7870</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>86</b> YRS.	IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b>		IF UNDER 24 HRS. HOURS <b>00</b> MIN. <b>00</b>		7. DATE OF BIRTH <b>Nov. 30, 1907</b> <b>Nov. 7, 1907</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>CHARLESTOWN CARE CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CATONSVILLE</b>				9c. COUNTY OF DEATH <b>BALTIMORE</b>							
RESIDENCE OF DECEDENT															
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>CARROLL</b>		10c. CITY, TOWN OR LOCATION <b>WESTMINSTER</b>				10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>630 BACHMAN VALLEY ROAD</b>				10f. ZIP CODE <b>20613</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
11. MARITAL STATUS <b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5 ±</b> College (1-4 or 5+) <b>5 ±</b>				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SCHOOL TEACHER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>EDUCATION</b>							
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE ACREE</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EVA LONGEST</b>									
19a. INFORMANT'S NAME (Type/Print) <b>GEORGE ACREE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12 EVERGREEN TRAIL - SEVERNA PARK, MD. 21146</b>											
20a. METHOD OF DISPOSITION <b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		DATE <b>3/7</b>		20c. LOCATION — City or Town, State <b>BALTIMORE</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>HUBBARD FUNERAL HOME, INC.</b> <b>4107 WILKENS AVE, BALTIMORE, MD 21229</b>											
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Cardiopulmonary arrest</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>ASCD</b>										Approximate Interval Between Onset and Death <b>minutes</b> <b>years</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>6</b> <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D26473</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/7/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BERNARD F. KZLOVSKY, MD</b> <b>Chelton, 711 MADONNACHOICE LA. BALTIMO</b>															
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE 											



94 06825

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Madeline D. Barrick</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>6</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>12:45 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>214 01 2205</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 1, 1917</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>North Arundel Hospital Association</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Glen Burnie</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Glen Burnie</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>304 Ryan Rd.</b>				10f. ZIP CODE <b>21061</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Domestic</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Murrill</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Julia Hayes</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Linda Lee Chew</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>287 Hickory Point Rd., Pasadena, MD 21122</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glen Haven Memorial Pk. 3/9/94</b>		20c. LOCATION — City or Town, State <b>Glen Burnie, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stella A. [Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>McCully Funeral Home of Pasadena 3204 Mountain Rd., Pasadena MD 21122</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b>							
Due to (or as a consequence of): <b>Chronic Renal failure</b>							
Due to (or as a consequence of):							
Due to (or as a consequence of):							
Due to (or as a consequence of):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive heart failure</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jonathan Jorman MD</i>				29c. LICENSE NUMBER <b>D23811</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/7/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J.P. Forman MD 407 S. Crain Glen Burnie Md 21061</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06826

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN C. BROOKS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 7, 1994</b>		3. TIME OF DEATH <b>6:00 A M</b>	
4. SOCIAL SECURITY NUMBER <b>217-05-3021</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUG. 1, 1905</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>4201 BARRINGTON ROAD</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MARYLAND</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>4201 BARRINGTON ROAD</b>			
10f. ZIP CODE <b>21229</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>1 YEAR</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>GENERAL MANAGER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>RESTAURANT</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WILHELM BROOKS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MAGDELINE HILDEBRANDT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FORREST BRAMBLE, JR.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>111 S. CALVERT STREET-SUITE 1400-BALITMORE, MD21202</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LOUDON PARK CEMETERY</b>		20c. DATE <b>3/3</b>		20d. LOCATION — City or Town, State <b>BALTIMORE</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD. 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Myocardial infarction</b> b. <b>Coronary artery disease c (angina)</b> c. <b>chronic lung disease</b> d. <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>1215538</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/7/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. WALTER B. KOPPEL - SUITE 308 - 1900 E. NORTHERN PARKWAY-BALTIMORE, MD.21239</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECRET  
POLICE

SECRET  
POLICE





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06827

1. DECEDENT'S NAME (First, Middle, Last) <u>Charles H. Brooks, Jr.</u>				2. DATE OF DEATH MONTH <u>03</u> DAY <u>05</u> YEAR <u>94</u>		3. TIME OF DEATH <u>11:55 AM</u>							
4. SOCIAL SECURITY NUMBER <u>212-20-3720</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>68</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>08/31/25</u>		8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>					
9a. FACILITY NAME (If not institution, give street and number) <u>University Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>			9c. COUNTY OF DEATH <u>Baltimore City</u>						
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Baltimore</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
10e. STREET AND NUMBER <u>7511 Flinty Plain Drive</u>				10f. ZIP CODE <u>21244</u>		10g. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>WW II</u>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>12th grade</u>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Ret: Maintenance Supervisor</u>		15b. KIND OF BUSINESS/INDUSTRY <u>University of MD at Baltimore</u>									
17. FATHER'S NAME (First, Middle, Last) <u>Charles H. Brooks, Sr.</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Christina R. Klaus</u>									
19a. INFORMANT'S NAME (Type/Print) <u>Mrs. Peggy Brooks</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7511 Flinty Plain Drive Baltimore, MD 21244</u>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Woodlawn Cemetery</u>		DATE <u>3/9</u>		20c. LOCATION — City or Town, State <u>Woodlawn, MD</u>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>James B. Covey</u>				22. NAME AND ADDRESS OF FACILITY <u>Loring Byers Funeral Directors, Inc.</u> <u>8728 Liberty Road Randallstown, MD 21133</u>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Pneumonia</u>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <u>Lung Cancer</u> c. d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Right sided CVA</u>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <u>George K. K... MD</u>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <u>03/5/94</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>George K. K... University Hospital Baltimore MD</u>													
31. DATE FILED (Month, Day, Year) <u>MAR 08 1994</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 94 06828

1. DECEDENT'S NAME (First, Middle, Last) <b>FRANCIS E. BRADY SR.</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>5</b> YEAR <b>94</b>		3. TIME OF DEATH <b>9:50 P M</b>	
4. SOCIAL SECURITY NUMBER <b>217-12-6511</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-12-17</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Northwest Hospital Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Randallstown</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Owings Mills</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>5000 Wards Chapel Road</b>			
10f. ZIP CODE <b>21117</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>8th grade</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Ret: Machinist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Black &amp; Decker Co.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Henry Brady</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elsie Mae McDonald</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Frances Brady</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5000 Wards Chapel Rd. Owings Mills, MD 21117</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lake View Mem. Park</b>		DATE <b>3/9</b>		20c. LOCATION — City or Town, State <b>Sykesville, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James B. Covert</b>				22. NAME AND ADDRESS OF FACILITY <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>CHRONIC RENAL FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Raymond Depestre MD</b>				29c. LICENSE NUMBER <b>D27157</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/5/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>KAYNOLD DEPESTRE NORTHWEST HOSPITAL CENTER</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <b>John S. Benson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE AMERICAN

LIBRARY

OF THE

CONGRESS

94 06829

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Jacqueline Y. Brown</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>4</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>0635 AM</b>	
4. SOCIAL SECURITY NUMBER <b>214-58-8871</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>44</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-22-50</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD</b>				9a. FACILITY NAME (If not institution, give street and number) <b>ST. AGNES HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>4240 FLOWERTON ROAD</b>	
10f. ZIP CODE <b>21229</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>AFR. AMERICAN</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>GOV'T WORKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N.S.A.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>ARTHUR ROACH</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HELEN HURT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>SHANTEL R. BROWN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>\$(\\$) FLOWERTON ROAD BALTIMORE, MD 21229</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WOODLAWN CEMETERY 3/9/94</b>		20c. LOCATION — City or Town, State <b>WOODLAWN, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217</b>			
23. PART I: Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CNS carcinomatosis</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>metastatic breast cancer</b> c. <b>metastatic breast cancer</b> d. <b>metastatic breast cancer</b> Approximate Interval Between Onset and Death <b>1-2 wks</b> <b>1 yr</b>							
PART II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER <b>D18587</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PAUL GORMLEY 900 CATON AVE BALTO MD 21229</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06830

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles Burton, Jr.</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>06</b> YEAR <b>94</b>		3. TIME OF DEATH <b>6:30 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>213 09 1909</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-25-07</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Francis Scott Key</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Balto.</b>		8c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Balto.</b>		10c. CITY, TOWN OR LOCATION <b>Edgemere</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2438 Lodge Farm Rd.</b>				10f. ZIP CODE <b>21219</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Contractor</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Burton</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Roberta Yancey</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary E. Burton</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2438 Lodge Farm Rd. Balto., Md. 21219</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus</b>		DATE <b>3/9</b>		20c. LOCATION — City or Town, State <b>Balto., Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i>				22. NAME AND ADDRESS OF FACILITY <b>James A. Morton &amp; Sons</b> <b>1701 Laurens St. Balto., Md. 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Renal Failure</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residencia <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>6</b> <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Humberto A. Rossi</i>				29c. LICENSE NUMBER <b>94015</b>		29d. DATE SIGNED (Month, Day, Year) <b>03/06/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Humberto A. Rossi 4940 Eastern Avenue Balto., Md. 21224</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


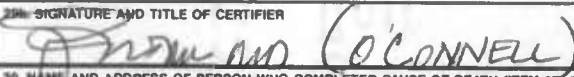





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06831

1. DECEDENT'S NAME (First, Middle, Last) <b>JOSEPH D Bowman</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>04</b> YEAR <b>94</b>		3. TIME OF DEATH <b>1809P</b>	
4. SOCIAL SECURITY NUMBER <b>212-80-6348</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>25</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>03/25/66</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Univ. of MD. Medical Systems</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>115 N. CAREY STREET</b>				10f. ZIP CODE <b>21223</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 TH</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>N/A</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ROBERT B. BOWMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JEANETTE SALLEY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JEANETTE SALLEY DAVIS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 454 KILMARNOCK, VIRGINIA 22482</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, corner, etc.) <b>KING MEMORIAL PARK</b>		20c. LOCATION — City or Town, State <b>03-09 RANDALLSTOWN, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH. - 1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>SEPSIS</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): c. <del>XXXXX</del> DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HIV</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>JEANNE M. O'CONNELL MD. UMMS</b>				29c. LICENSE NUMBER <b>Resident</b>		29d. DATE SIGNED (Month, Day, Year) <b>03/04/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JEANNE M. O'CONNELL MD. UMMS</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

EX-34 BOMM

EX-34 BOMM

SECTION WHEN

SECTION WHEN

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06832

1. DECEDENT'S NAME (First, Middle, Last) <b>MICHAEL E. BOLEWICKI</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 1, 1994</b>		3. TIME OF DEATH M			
4. SOCIAL SECURITY NUMBER <b>219-26-3800</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>55</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 9, 1938</b>		8. BIRTHPLACE (State or Foreign Country) <b>Baltimore City</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>102-A Meadow Rd.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Belair, Maryland</b>				9c. COUNTY OF DEATH <b>Harford</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Belair, Maryland</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>102-A Meadow Rd.</b>				10f. ZIP CODE <b>21014</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>KOREAN</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>shipping &amp; Receiving</b>		15b. KIND OF BUSINESS/INDUSTRY <b>A.J. Buck &amp; Son</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Michael C. Bolewicki</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Julia Helowicz</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Grisel H. Bolewicki</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>102-A Meadow Road Belair, Maryland 21014</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Stanislaus Cemetery 3/5/1994</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>E. F. Lassahn</i>		22. NAME AND ADDRESS OF FACILITY <b>E. F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md. 21087</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Hepatic Failure</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <i>Cirrhosis</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marion C. Kowalewski M.D.</i>				29c. LICENSE NUMBER <b>021022</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-3-94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Marion C. Kowalewski, M.D. 8604 Harford Rd. Balto., Md. 21234 (668-7030)</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06833

1. DECEDENT'S NAME (First, Middle, Last) <b>Eleanor M. Clarke</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 04, 1994</b>		3. TIME OF DEATH <b>4:00 P M</b>					
4. SOCIAL SECURITY NUMBER <b>215-42-8231</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11/02/10</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>6238 Gilston Park Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Catonsville</b>			9c. COUNTY OF DEATH <b>Baltimore</b>				
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Catonsville</b>			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER <b>6238 Gilston Park Road</b>				10f. ZIP CODE <b>21228</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b> Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>						
17. FATHER'S NAME (First, Middle, Last) <b>John C. Breneman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>May Greenlan</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Arthur P. Clarke, III</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6238 Gilston Park Road Catonsville, MD 21228</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery 3/7</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>George E. MacNabb</b>				22. NAME AND ADDRESS OF FACILITY <b>MacNabb Funeral Home, P.A. 301 Frederick Rd. Balto., MD 21228</b>							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>renal failure</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Generalized atherosclerosis</b> <b>Coronary artery disease</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death <b>3 mo.</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Alexander</b>						29c. LICENSE NUMBER <b>708780</b>		29d. DATE SIGNED (Month, Day, Year) <b>03/05/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ALEXANDRO MEJIA MD 405 Frederick Rd Baltimore 21228</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>JOSEPH ARTHUR CARRIER</u> <u>JOSEPH</u> <u>ARTHUR</u> <u>CARRIER, SR.</u>				2. DATE OF DEATH MONTH <u>03</u> DAY <u>06</u> YEAR <u>1994</u>		3. TIME OF DEATH <u>5:00 PM</u> M	
4. SOCIAL SECURITY NUMBER <u>032-26-1172</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>57</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>10-22-1936</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>HOWARD COUNTY GENERAL</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>COLUMBIA</u>		9c. COUNTY OF DEATH <u>HOWARD</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>MARYLAND</u>		10b. COUNTY <u>ANNE ARUNDEL</u>		10c. CITY, TOWN OR LOCATION <u>ANNAPOLIS</u>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>880 RUDDER WAY</u>				10f. ZIP CODE <u>21401</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>1954-1958</u>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>4</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>WARE HOUSEMAN</u>		16b. KIND OF BUSINESS/INDUSTRY <u>MACK TRUCK</u>			
17. FATHER'S NAME (First, Middle, Last) <u>JOSEPH CARRIER</u>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <u>BLANDINE DICOUS</u> BLANDINE DICOUS			
19a. INFORMANT'S NAME (Type/Print) <u>ELISABETH J. CARRIER</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>880 RUDDER WAY, ANNAPOLIS, MARYLAND 21401</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>NICHOLS BETHEL CEMETERY</u> DATE <u>3/6/94</u>		20c. LOCATION — City or Town, State <u>ODENTON, MARYLAND</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Samuel C. Hwaatt</u>				22. NAME AND ADDRESS OF FACILITY <u>SINGLETON FUNERAL HOME,</u> <u>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Acute myocardial infection</u> DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <u>Atherosclerotic disease</u> DUE TO (OR AS A CONSEQUENCE OF):							
{ <u>congestive heart failure</u> DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26d. DESCRIBE HOW INJURY OCCURRED				26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				26g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Lisa Murray, MD</u>				29c. LICENSE NUMBER <u>D38526</u>		29d. DATE SIGNED (Month, Day, Year) <u>3/7/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <u>MAR 08 1994</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Pondell</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ITEMS: 23 PART I, 27, PER MEO FILM G-709 3/11/94 t.t

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 94 06835

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES CUTTS, JR.</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>01</b> YEAR <b>94</b>		3. TIME OF DEATH <b>7:59 A.</b> M	
4. SOCIAL SECURITY NUMBER <b>214 64 8209</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>39</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6-18-54</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Liberty Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto.</b>	
9c. COUNTY OF DEATH							
10a. STATE <b>Md.</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Balto.</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>1906 E. 31st. Street</b>				10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Vendor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self Employed</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Cutts, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ella Farrar</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Barbara Bell</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3918 Ridgewood Ave. Balto., Md. 21215</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King Memorial Park 3/5</b>		DATE <b>3/5</b>		20c. LOCATION — City or Town, State <b>Balto., Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i>				22. NAME AND ADDRESS OF FACILITY <b>James A. Morton &amp; Sons 1701 Laurens St. Balto., Md. 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ann Dixon</i>					
		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>Mar 2, 1994</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ann Dixon 111 Penn Street, Balto., Md. 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>		32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Rodale</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06836

11:48AM

1. DECEDENT'S NAME (First, Middle, Last) <i>Mary Elizabeth Cochran</i>				2. DATE OF DEATH <i>3-1-94</i> MONTH DAY YEAR		3. TIME OF DEATH <i>11:48 A</i>	
4. SOCIAL SECURITY NUMBER <i>219-12-5812</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>84</i> YRS.		7. DATE OF BIRTH <i>May 15, 1909</i> (Month, Day, Year)	
9a. FACILITY NAME (If not institution, give street and number) <i>FALLSTON GENERAL HOSPITAL</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>FALLSTON</i>		9c. COUNTY OF DEATH <i>HARFORD</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Harford</i>		10c. CITY, TOWN OR LOCATION <i>Fallston, Md.</i>	
10e. STREET AND NUMBER <i>3346 Fallston Road</i>				10f. ZIP CODE <i>21047</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i>		15b. KIND OF BUSINESS/INDUSTRY <i>Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>William Roach</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Elizabeth Horan</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Edward L. Cochran, Jr.</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6858 Sanner Road Clarksville, Md. 21029</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Johns Catholic Cem. 3/4/1994</i>		20c. LOCATION — City or Town, State <i>Hydes, Md. 21082</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>E. F. Lassahn</i>				22. NAME AND ADDRESS OF FACILITY <i>E.F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md. 21087</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>U&amp;I bleed - massive</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.  Approximate interval Between Onset and Death <i>1 hr.</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cervical Cancer - metastatic</i> <i>CVA</i> <i>Atrial Fibrillation</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TYPE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>D34652</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/1/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>S. HASWELL 2 N. AVE SUITE 101 BELAIR MD 21014</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 08 1994</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06837

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <i>Marion</i>				2. DATE OF DEATH MONTH <i>March</i> DAY <i>3</i> YEAR <i>1994</i>				3. TIME OF DEATH <i>6:20 P</i>	
4. SOCIAL SECURITY NUMBER <i>220-22-1204</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <i>66</i> YRS.		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Joseph Richey Hospice</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>				9c. COUNTY OF DEATH <i>--</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Baltimore</i>				10c. CITY, TOWN OR LOCATION <i>Baltimore</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>1025 W. 36th Street</i>				10f. ZIP CODE <i>21211</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WWII</i>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9</i> College (14 or 5+) <i>College</i>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Cable Splicer</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Gas and Electric Co.</i>				17. FATHER'S NAME (First, Middle, Last) <i>Thomas W. Cassort</i>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Alma O. Johnson</i>				19a. INFORMANT'S NAME (Type/Print) <i>Jennifer Cassort</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1424 Union Avenue, Baltimore, Maryland 21211</i>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Maryland Veterans Cem. 3/7</i>				20c. LOCATION — City or Town, State <i>Garrison Forest, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lynn Burger Henss</i>				22. NAME AND ADDRESS OF FACILITY <i>Burgee-Henss Funeral Home 21211 3631 Falls Road, Baltimore, Maryland</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Manitonia</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <i>Rectal Carcinoma with metastases</i> b. <i>4 yrs</i> c. <i>Due to (or as a consequence of):</i> d. <i>Due to (or as a consequence of):</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <i>M</i>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alice B. Heister MD</i>				29c. LICENSE NUMBER <i>DD 5055</i>	
29d. DATE SIGNED (Month, Day, Year) <i>3-4-94</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Alice B. Heister MD 630 W. Fayette St. Baltimore, Md. 21201</i>				31. DATE FILED (Month, Day, Year) <i>MAR 08 1994</i>	
32. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

RECEIVED

RECEIVED

*James D. [illegible]*

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06838

1. DECEDENT'S NAME (First, Middle, Last) <b>Rufus W. Cole</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>4</b> YEAR <b>94</b>		3. TIME OF DEATH <b>2:05</b> M	
4. SOCIAL SECURITY NUMBER <b>244 42 7634</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>65</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>7 28 28</b>		8. BIRTHPLACE (State or Foreign Country) <b>N.C.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>VA Medical Center, FORT HOWARD</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>MD.</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>123 W. 29th St.</b>				10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1950-1952</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Painter</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self Employed</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Rueben Sole</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sadie Lowe</b>			
19a. INFORMANT'S NAME (Type/Print) <b>L. Maurece Cole</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>71 Tallow Ct. Balto., Md. 21244</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest</b>		DATE <b>3/8</b>		20c. LOCATION — City or Town, State <b>Balto., Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James Morton R H</i>				22. NAME AND ADDRESS OF FACILITY <b>James A. Morton &amp; Sons</b> <b>1701 Laurens St. Balto., Md. 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Terminal Metastatic Carcinoma, Primary Site Unk</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CARDIAC ARRHYTHMIA</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marcos Galicia MD</i>				29c. LICENSE NUMBER <b>D15698</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARCOS GALICIA, MD. 9600 NORTH POINT RD., FORT HOWARD, MD. 21052</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06839

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES EDWARD DEMBY, SR.</b>				2. DATE OF DEATH MONTH <b>MAR</b> DAY <b>05</b> YEAR <b>94</b>		3. TIME OF DEATH <b>6:10 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>212-42-0606</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>52 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>07-10-41</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1630 N. MONTFORD AVE</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>720 E. 35th ST.</b>		10f. ZIP CODE <b>21218</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>VIETNAM</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CHEF</b>				16b. KIND OF BUSINESS/INDUSTRY <b>ROYAL RESTURANT</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM D. DEMBY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GLADYS TOLIVER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CARIAN DEMBY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>720 E. 35th ST. BALTIMORE, MD. 21218</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST VA 3/11</b>		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>BETTS FUNERAL HOME 1129 N. CAROLINE ST. BALTO, MD 21213</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAR 5, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLIE, JR. MD 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 94 06840

1. DECEDENT'S NAME (First, Middle, Last) <b>Carole Jeanne Dalrymple</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Mar. 7, 1994</b>		3. TIME OF DEATH <b>5:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>219-56-4624</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>43</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08/30/50</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. FACILITY NAME (If not Institution, give street and number) <b>Manor Care Towson</b>			
10. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>				11. COUNTY OF DEATH <b>Baltimore</b>			
12. STATE <b>Maryland</b>		13. COUNTY <b>Anne Arundel</b>		14. CITY, TOWN OR LOCATION <b>Pasadena</b>		15. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
16. STREET AND NUMBER <b>867 De Franceaux Harbour</b>				17. ZIP CODE <b>21122</b>		18. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
19. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		20. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		22. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
23. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>12</b>		24. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Social Worker</b>		25. KIND OF BUSINESS/INDUSTRY <b>Franklin Square Hosp.</b>			
26. FATHER'S NAME (First, Middle, Last) <b>Daniel Jackson Sr.</b>				27. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Doris J. Braun</b>			
28. INFORMANT'S NAME (Type/Print) <b>Darcie C. Dalrymple</b>				29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>867 De Franceaux Harbour Pasadena, MD 21122</b>			
30. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 03/08</b>		32. LOCATION — City or Town, State <b>Baltimore, MD 21228</b>			
33. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>George E. MacNabb</b>				34. NAME AND ADDRESS OF FACILITY <b>Cremation Society of Md., Inc. 299 Frederick Rd. Balto., MD 21228</b>			
<p>23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>brain CA: glioblastoma multiforme</b></p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</p> <p>a. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						<p>24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</p> <p>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</p>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <b>Theodore G. Honk</b>				29b. LICENSE NUMBER <b>D41104</b>		29c. DATE SIGNED (Month, Day, Year) <b>3-7-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Theodore G. Honk M.D. 7825 York Road Baltimore, MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>		32. REGISTRAR'S SIGNATURE <b>Julie Sanders-Randall</b>					



94 06841

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Concetta DeRosa				2. DATE OF DEATH MONTH DAY YEAR March 5, 1994		3. TIME OF DEATH 5:15 P. M	
4. SOCIAL SECURITY NUMBER 216-07-0304		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) April 5, 1908	
9a. FACILITY NAME (If not institution, give street and number) Golden Age Guest Home				9b. CITY, TOWN OR LOCATION OF DEATH Sykesville		9c. COUNTY OF DEATH Carroll	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3320 Morvia Road				10f. ZIP CODE 21214		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machine Operator		16b. KIND OF BUSINESS/INDUSTRY Clothing Mfrg.			
17. FATHER'S NAME (First, Middle, Last) Benjamin Ferraro				18. MOTHER'S NAME (First, Middle, Maiden Surname) Phyllis Nespola			
19a. INFORMANT'S NAME (Type/Print) Joseph Ferraro				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Bird View Road, Westminster, Maryland			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Most Holy Redeemer Cem. 3-9-94		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wallace S. Brooks, Jr.				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Alzheimer's Disease</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Patrick A. Turnes		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Patrick Turnes, M.D. 1425 Liberty Road, Eldersburg, Maryland 21784							
31. DATE FILED (Month, Day, Year) MAR 08 1994		32. REGISTRAR'S SIGNATURE John Benison-Rudolph					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06842

1. DECEDENT'S NAME (First, Middle, Last) <b>EFFIE W. DAYHOFF</b>				2. DATE OF DEATH MONTH <b>3</b> / DAY <b>4</b> / YEAR <b>1994</b>		3. TIME OF DEATH <b>3:50 P</b> M	
4. SOCIAL SECURITY NUMBER <b>216-05-1661</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3/13/1903</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>BON SECOUR EXTENDED CARE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ELLICOTT CITY</b>		9c. COUNTY OF DEATH <b>HOWARD</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>HOWARD</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5130 EDMONDSON AVENUE</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>SECRETARY</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SECRETARY</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CAN COMPANY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JAMES H. WHEATLEY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ALICE G. STRECKER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>EDYTHE KELSO</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4334 BARTHOLOW ROAD, SYKESVILLE, MD, 21784</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LORRAINE PARK CEMETERY 3/9/94</b>		20c. LOCATION — City or Town, State <b>WOODLAWN, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>WITZKE FUNERAL HOME, 1630 EDMONDSON AVE. CATONSVILLE, MD, 21228</b>			
23. PART I. Enter the diseases, or complications met caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiovascular disease</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>High blood pressure</b>  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Recurrent psychiatric depression</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <b>1</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D31575</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/7/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>KOLODRUBETZ 9501 Old Annapolis Rd Ellicott City MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



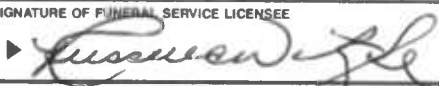



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06843

1. DECEDENT'S NAME (First, Middle, Last) <b>ROSE V. D'ANNA</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>06</b> YEAR <b>94</b>		3. TIME OF DEATH <b>9:55 P. M.</b>	
4. SOCIAL SECURITY NUMBER <b>216-14-4226</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02-03-18</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>4815 FREDERICK AVENUE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>MARYLAND</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4815 FREDERICK AVENUE</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>HOUSE WIFE</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>LUIGI MANGIONE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EUGENIA SETA</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LAURA D'ANNA (DAUGHTER)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4815 FREDERICK AVENUE BALTIMORE, MARYLAND 21229</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>NEW CATHEDRAL CEMETERY 03/10/94</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>LEROY M &amp; RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE, MARYLAND</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Pancreatic Cancer</u></b> a. DUE TO (OR AS A CONSEQUENCE OF):  Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <b>14mo</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Henry A. Pitt, M.D.</b>		29c. LICENSE NUMBER <b>D21906 MD</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/7/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>HENRY A. PITT BLALOCK 688 JOHNS HOPKINS HOSP, BALT, MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>LEONA DALL</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>5</b> YEAR <b>1994</b>				3. TIME OF DEATH <b>1:00 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>219-26-4050</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>97</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN. 27, 1897</b>		8. BIRTHPLACE (State or Foreign Country) <b>LITHUANIA</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>MERCY MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE</b>				10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>115 W. SARATOGA STREET</b>				10f. ZIP CODE <b>21201</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>UNKNOWN</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>LANDLORD</b>				16b. KIND OF BUSINESS/INDUSTRY <b>ROOMING HOUSES</b>	
17. FATHER'S NAME (First, Middle, Last) <b>ALEXANDER RINGIS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELIZABETH SIMONITIS</b>					
19a. INFORMANT'S NAME (Type/Print) <b>ADRIANE POLLMEIER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>212 SUNSET DRIVE - GLEN BURNIE, MD. 21060</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LOUDON PARK CEMETERY</b>				20c. LOCATION — City or Town, State <b>3/9 BALTIMORE</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD. 21229</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>FATAL CARDIAC ARRHYTHMIA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <b>CORONARY ARTERY INSUFFICIENCY</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death <b>MINUTES</b> <b>15 YEARS</b> <b>20 YEARS</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACUTE INFECTION WITH FEVER.</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Joseph D. Notarangelo M.D.</b>				29c. LICENSE NUMBER <b>507316</b>				29d. DATE SIGNED (Month, Day, Year) <b>MARCH 7, 94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. JOSEPH D. NOTARANGELO - SUITE 909 - 301 ST. PAUL PLACE - BALTIMORE, MD. 21202</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE 					

SECRET BOMB

SECRET



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 068451

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM E. DODSON</b>			2. DATE OF DEATH MONTH DAY YEAR <b>03-04-94</b>		3. TIME OF DEATH <b>1 PM</b>						
4. SOCIAL SECURITY NUMBER <b>215-32-9108</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>59</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>01-02-35</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Northwest Hospital Center</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>Randallstown</b>			9c. COUNTY OF DEATH <b>Baltimore</b>					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Pikesville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>30 Tentmill Lane Apt. I</b>			10f. ZIP CODE <b>21208</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>						
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th grade</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>			15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Facility Specialist</b>			15b. KIND OF BUSINESS/INDUSTRY <b>NSA</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Willie Dodson</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dora Dodson</b>								
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Maxine Dodson</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>30 Tentmill Lane Apt. I Pikesville, MD 21208</b>								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Pleasant Cemetery 3/7</b>		20c. LOCATION — City or Town, State <b>Gamber, Maryland</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pulmonary fibrosis</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. SIGNATURE AND TITLE OF CERTIFIER <b>Kathryn T. George MD Pathologist</b>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>3/4/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>						32. REGISTRAR'S SIGNATURE 					

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06846

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) Charles Henry Dannettel Sr.		2. DATE OF DEATH MONTH DAY YEAR March 6, 1994		3. TIME OF DEATH M
4. SOCIAL SECURITY NUMBER 215-01-5499	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 84 YRS.	7. DATE OF BIRTH (Month, Day, Year) July 17, 1909	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) 417 Kemper Road		9b. CITY, TOWN OR LOCATION OF DEATH Joppa		9c. COUNTY OF DEATH Harford
10a. STATE Md.		10b. COUNTY HARford		10c. CITY, TOWN OR LOCATION Joppa
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 417 Kemper Road		
10f. ZIP CODE 21085		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bookbinder		16b. KIND OF BUSINESS/INDUSTRY Maple Press		
17. FATHER'S NAME (First, Middle, Last) Charles Henry Dannettel		18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Curran		
19a. INFORMANT'S NAME (Type/Print) Elizabeth Miller		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1508 Westview Court Belair Md. 21015		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 3/9/94		20c. LOCATION — City or Town, State Baltimore Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connelly		22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHRONIC RENAL FAILURE b. COLON CARCINOMA c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				
24. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				
28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER H41069 29d. DATE SIGNED (Month, Day, Year) 3-7-94				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Kaman 1308 Business Center Way Edgewood Md.				
31. DATE FILED (Month, Day, Year) MAR 08 1994 32. REGISTRAR'S SIGNATURE				





94-0977-510  
ML

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06847

1. DECEDENT'S NAME (First, Middle, Last) <b>TYLER EDWARDS</b>				2. DATE OF DEATH MONTH <b>FEB.</b> DAY <b>27</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>12:30</b>	
4. SOCIAL SECURITY NUMBER <b>219-02-7906</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>10</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>03-24-83</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>2035 HOLLINS STREET</b>		8b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				8c. COUNTY OF DEATH <b>MD</b>	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2035 HOLLINS ST.</b>				10f. ZIP CODE <b>21223</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary <b>(0-12)</b> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>				16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>JAMES EDWARDS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>TYRLETT GOOD</b>			
19a. INFORMANT'S NAME (Type/Print) <b>PHYLLIS ROUZER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>700 E. 41st ST. BALTIMORE, MD. 21218</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>DULANEY VALLEY MEM</b>		20c. LOCATION — City or Town, State <b>3/4 COCKEYSVILLE, MD.</b>		20d. DATE <b>3/4</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>BETTS FUNERAL HOME 1129 N. CAROLINE ST. BALTIMORE, MARYLAND 21213</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SMOKE INHALATION</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>INSPECTION</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>02/26/94</b>		28b. TIME OF INJURY <b>11:41P</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <b>VICTIM OF A HOUSE FIRE</b>		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) <b>HOME</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>2035 HOLLINS STREET</b>	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB. 27, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEMS: 1. &amp; 17. PER F.H. FILM G-709 3/8/94 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06848

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <del>REGINA FEASTER</del> REGINA R. FEASTER				2. DATE OF DEATH MONTH DAY YEAR 03 March 3 94		3. TIME OF DEATH 6:31 P.M.	
4. SOCIAL SECURITY NUMBER 217-90-5967		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 29 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02-21-65	
9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH n/a	
10a. STATE MARYLAND				10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 1505 E. PRESTON STREET				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 TH College (1-4 or 5+) n/a		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) n/a		16b. KIND OF BUSINESS/INDUSTRY n/a			
17. FATHER'S NAME (First, Middle, Last) <del>ERNESTINE FEASTER</del> RICHARD FEASTER				18. MOTHER'S NAME (First, Middle, Maiden Surname) ERNESTINE DAVIS			
19a. INFORMANT'S NAME (Type/Print) ERNESTINE FEASTER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 937 ABBOTT COURT, BALTIMORE, MARYLAND 21202			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY 03-07		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ernestine Feaster</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.- 1101 E. NORTH AVENUE			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>SPDK</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>ENDOCARDIOS</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>IVDA</i> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 24 hr 7 weeks 20 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario Beltran</i> P64 TL				29c. LICENSE NUMBER A+ 2438 946		29d. DATE SIGNED (Month, Day, Year) 3/3/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO BELTRAN UMH							
31. DATE FILED (Month, Day, Year) MAR 08 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.




1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

1. DECEDENT'S NAME (First, Middle, Last) <b>ELIZABETH FINNEY</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>5</b> YEAR <b>94</b>		3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER <b>213-14-4712</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>85</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>7-26-08</b>		8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>HARBOR INN 1213 LIGHT ST.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>			9c. COUNTY OF DEATH				
RESIDENCE OF DECEDENT											
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER <b>69 S. MORLEY ST.</b>				10f. ZIP CODE <b>21229</b>			10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>OTH</b> College (1-4 or 5 +)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life—Do NOT use retired) <b>DOMESTIC</b>		15b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) <b>LEWIS TANKARD</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>VOLLIE TANKARD</b>							
19a. INFORMANT'S NAME (Type/Print) <b>CAROLYN BROOKS</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1101 N. STERLING BLVD, STERLING VA 20164</b>									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other facility) <b>CHAR HILL</b>		20c. DATE <b>3/10/94</b>		20d. LOCATION — City or Town, State <b>CLIA PARKIE MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FUNERAL HOME <b>GARY P. MARCH FUNERAL HOME INC. 270 FREDERICK PASS BALTIMORE MD 21229</b>							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>1) Atherosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>2) Sudden Death</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>S. R. R. R.</b>				29c. LICENSE NUMBER <b>D30641</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/8/94</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ROMESH SABAPATHY M.D. Suite 308 &amp; 21 N. Eulaw St Balto MD 21201</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>		32. REGISTRAR'S SIGNATURE <b>Julia Anderson-Rodell</b>									

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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06851

1. DECEDENT'S NAME (First, Middle, Last) Homer Fischer		2. DATE OF DEATH MONTH 2 DAY 28 YEAR 94		3. TIME OF DEATH 2:03PM M	
4. SOCIAL SECURITY NUMBER 172-24-7773		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.	
7. DATE OF BIRTH (Month, Day, Year) 1/19/26		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
10a. STATE Maryland		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Little Orleans	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER Box 84		10f. ZIP CODE 21766	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 10/17/44-8/16/46 WWII	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Business Agent/ Truck Driver		16b. KIND OF BUSINESS/INDUSTRY Teamsters Local 992		17. FATHER'S NAME (First, Middle, Last) William M. Fischer	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Zoe Pearl Northcraft		19a. INFORMANT'S NAME (Type/Print) Helen L. Fischer		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 84 Little Orleans, MD. 21766	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Amaranth Brethren Cem. 03/4/94		20c. LOCATION — City or Town, State Warfordsburg, PA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Grove F.H. 141 W. Main St. PO Box 368 Hancock, MD. 21750		23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Mitral stenosis DUE TO (OR AS A CONSEQUENCE OF): b. Rheumatic valve disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  Dpty Med ex		29c. LICENSE NUMBER D 09157	
29d. DATE SIGNED (Month, Day, Year) 2/28/94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Snow, M.D. 124 w 3rd st Cumb MD 21502		31. DATE FILED (Month, Day, Year) MAR 08 1994	
32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94-1002-510

blh

94 06852

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Michael Leigh Fugate				2. DATE OF DEATH MONTH DAY YEAR Feb 28 1994		3. TIME OF DEATH 1000 A M	
4. SOCIAL SECURITY NUMBER 172-42-4321		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 42 YRS.	7. DATE OF BIRTH (Month, Day, Year) May 27, 1951		8. BIRTHPLACE (State or Foreign Country) Michigan	
9a. FACILITY NAME (If not institution, give street and number) Parking Lot at- Bon Secours Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH ---	
10a. STATE Pennsylvania		10b. COUNTY York		10c. CITY, TOWN OR LOCATION Shrewsbury		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5 Whitcraft Lane				10f. ZIP CODE 17361		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineering Specialist		16b. KIND OF BUSINESS/INDUSTRY Building Controls			
17. FATHER'S NAME (First, Middle, Last) Donald Fugate				18. MOTHER'S NAME (First, Middle, Maiden Surname) Patricia Bradley			
19a. INFORMANT'S NAME (Type/Print) Virginia L. Fugate				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Whitcraft Lane, Shrewsbury, PA 17361			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Freedom Cemetery March 3, 1994		20c. LOCATION — City or Town, State New Freedom, PA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J. J. Hartenstein</i>				22. NAME AND ADDRESS OF FACILITY J. J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Injuries DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) Feb 28 1994		28b. TIME OF INJURY 0945 M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED Pedestrian struck by truck		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) parking lot		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Bon Secours Hospital	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) Mar. 01 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis J. Chute, MD. 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAR 08 1994		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06853

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>MARY ELLA GIBSON</u> <i>Mary E. Gibson</i>				2. DATE OF DEATH MONTH <u>3</u> DAY <u>4</u> YEAR <u>94</u>		3. TIME OF DEATH <u>13:45</u> M	
4. SOCIAL SECURITY NUMBER <u>276-22-4142</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>67</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>5/09/26</u>	
8. BIRTHPLACE (State or Foreign Country) <u>VIRGINIA</u>							
9a. FACILITY NAME (If not institution, give street and number) <u>Mercy Medical Center</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		9c. COUNTY OF DEATH <u>n/a</u>	
10a. STATE <u>MARYLAND</u>				10b. COUNTY <u>n/a</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <u>572 W Preston St</u>				10f. ZIP CODE <u>21202</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>B BLACK</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8 TH</u> College (1-4 or 5+) <u></u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>HOME MAKER</u>		16b. KIND OF BUSINESS/INDUSTRY <u>n/a</u>	
17. FATHER'S NAME (First, Middle, Last) <u>CHARLIE WHITE</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>CLARA LOUISE TRAMMUELL</u>			
19a. INFORMANT'S NAME (Type/Print) <u>SHEILA GIBSON</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>572 W. PRESTON STREET, BALTIMORE, MD 21201</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>WOODLAWN CEMETERY</u>		20c. LOCATION — City or Town, State <u>03-10 WOODLAWN, MD</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Debbie K. Jones</i>				22. NAME AND ADDRESS OF FACILITY <u>WM. C. MARCH FH.- 1101 E. NORTH AVENUE</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Metastatic Lung Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Smoking</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u></u> DUE TO (OR AS A CONSEQUENCE OF): d. <u></u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ischemic Encephalopathy</u> <u>Respiratory Distress</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Christopher P Chambers</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <u>3/4/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Christopher P Chambers 301 St Paul Place Balto. MD 21202</u>							
31. DATE FILED (Month, Day, Year) <u>MAR 08 1994</u>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



94-0973-510

UNK 94-33

BKK

94 06854

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>VILLET</b>				2. DATE OF DEATH MONTH <b>FEB</b> DAY <b>27</b> YEAR <b>1994</b>				3. TIME OF DEATH <b>0030</b> A M	
4. SOCIAL SECURITY NUMBER <b>UNKNOWN</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>29</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-5-64</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>2035 HOLLINS ST.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE <b>Md.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTO.</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>700 E. 41st Street</b>				10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (14 or 16+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Unemployed</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Samuel Jones</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Phyllis Green</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Phyllis Rowzer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>700 E. 41st Street Balt. Md. 21218</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <b>Bethesda Mem. Grnd. Bethesda, Md.</b>		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Patricia Butt</b>				22. NAME AND ADDRESS OF FACILITY <b>BETTS FUNERAL HOME 1129 N. Caroline St</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>SMOKE INHALATION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO <b>Illegible</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>02-26-1994</b>		28b. TIME OF INJURY <b>2341</b> M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT VICTIM OF FIRE</b>	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>2035 HOLLINS ST.</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>BALTIMORE CITY</b>					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Illegible</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB 27, 1994</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GARY ANTON D. KORON 111 Penn Street, Baltimore, Maryland 21201</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				REGISTRAR'S SIGNATURE <b>Illegible</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94-1135-510

blh

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06855

1. DECEDENT'S NAME (First, Middle, Last) <b>Nellie Goodwin</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Mar 5 1994</b>		3. TIME OF DEATH HOURS MIN. <b>1535</b>	
4. SOCIAL SECURITY NUMBER <b>214-22-3793</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-2-24</b>	
8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1103 Tiffany Court</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1103 TIFFANY COURT</b>	
10f. ZIP CODE <b>21201</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary (1-12) <b>12TH</b> College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SALES</b>		16b. KIND OF BUSINESS/INDUSTRY <b>RETAIL</b>	
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY E. STEVENSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>BREANDA M. GOODWIN-WARREN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4909 CONWAY TERR, FREEMONT CALIF 94555-2805</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING MOUNT, PA. 3-10-94</b>			
20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>GARY T. MARCH</b>			
22. NAME AND ADDRESS OF FUNERAL HOME <b>270 FREDERICK ST. BALTIMORE, MD 21201</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Myocardial Infarction</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):				PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>Mar 5 1994</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dennis J. Chute MD</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>			
29d. DATE SIGNED (Month, Day, Year) <b>Mar 6 1994</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>			
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO BE COMPLETED BY FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06856

1. DECEDENT'S NAME (First, Middle, Last) (AKA) Margaret Lucille Golden M. Lucille Spiegel Golden				2. DATE OF DEATH MONTH DAY YEAR March 1, 1994		3. TIME OF DEATH 8:18 P. M					
4. SOCIAL SECURITY NUMBER 166-30-9657		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 31, 1914		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) 4044 Holly Knoll Drive				9b. CITY, TOWN OR LOCATION OF DEATH Glen Arm			9c. COUNTY OF DEATH Baltimore County				
RESIDENCE OF DECEDENT				10a. STATE Maryland		10b. COUNTY Baltimore County		10c. CITY, TOWN OR LOCATION Glen Arm			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 4044 Holly Knoll Drive		10f. ZIP CODE 21057		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 12 years		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		17. KIND OF BUSINESS/INDUSTRY Homemaking							
17. FATHER'S NAME (First, Middle, Last) Joseph Spiegel				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude West							
19a. INFORMANT'S NAME (Type/Print) Mrs. Linda Lou Ormsby				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4044 Holly Knoll Drive, Glen Arm, MD 21057							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Beaver Dam Cemetery		OATE 3/5		20c. LOCATION — City or Town, State Wattsburg, Pennsylvania					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Martin D. Lawson				22. NAME AND ADDRESS OF FACILITY Dulaney Valley Home of Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd, Timonium, Maryland 21093							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): b. congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Elisabeth K. Lucas, MD				29c. LICENSE NUMBER 035817		29d. DATE SIGNED (Month, Day, Year) 3/3/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Elisabeth Lucas, M.D. 204 E. Joppa Road, Towson, Maryland 21204											
31. DATE FILED (Month, Day, Year) MAR 08 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall							



94 06857

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Kathleen A GRAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>03 02 94</b>		3. TIME OF DEATH <b>10 50 PM</b>	
4. SOCIAL SECURITY NUMBER <b>212-32-1389</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>97</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02 22 1897</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Massachusetts</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Charlestown Care Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Catonsville</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Catonsville</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>711 Maiden Choice Lane</b>	
10f. ZIP CODE <b>21228</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (14 or 5+) <b>4</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Teacher</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Education</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Emil GRAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katherine O'SHANNACY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Nathan G. Chernoff</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Balto, MD 21202 Suite 1220 One Calvert Plaza 201 E. Baltimore St.</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Druid Ridge Cemetery 3/05</b>			
20c. LOCATION — City or Town, State <b>Pikesville, MD</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>M. Neal Coleman</b>			
22. NAME AND ADDRESS OF FACILITY <b>HUBBARD FUNERAL HOME, INC. 4107 Wilkens Ave, Baltimore, MD 21229</b>				23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Renal Failure</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Dehydration</b> DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Sharon J. McGormack MD</b>			
29c. LICENSE NUMBER <b>D38762</b>				29d. DATE SIGNED (Month, Day, Year) <b>3/3/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Sharon J. McGormack MD</b>				31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>			
32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06858

1. DECEDENT'S NAME (First, Middle, Last) <b>John D Geidt</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 4, 1994</b>		3. TIME OF DEATH <b>12:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>156-12-1477</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 5, 1914</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Manor Care Ruxton</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baldwin</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>3 Ascot Court</b>			
10f. ZIP CODE <b>21013</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Professional Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>State of Maryland</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Albert Geidt</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Merle May Daads</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Charles Shoemaker</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21013 13500 Alliston Drive, Baldwin, Maryland</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. John's Cemetery 3/8</b>		20c. LOCATION — City or Town, State <b>Hydes, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Walter J. Henss</i>				22. NAME AND ADDRESS OF FACILITY <b>Burgee-Henss Funeral Home 21211 3631 Falls Road, Baltimore, Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b> a. DUE TO (OR AS A CONSEQUENCE OF): <b>Causes</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>Smoker</b> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>Wks</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark Amos MD</i>				29c. LICENSE NUMBER <b>034521</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-7-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94-1120-510

DWG

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-709 3/17/94 t.t.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06859

1. DECEDENT'S NAME (First, Middle, Last) EDWARD HENDERSON				2. DATE OF DEATH MONTH MARCH DAY 04 YEAR 94		3. TIME OF DEATH 4:50P M	
4. SOCIAL SECURITY NUMBER 212-78-8712		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 27 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-14-67	
9a. FACILITY NAME (If not institution, give street and number) 4900 HILLEN ROAD				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10a. STREET AND NUMBER 1526 STONEWOOD ROAD				10f. ZIP CODE 21239		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9TH College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16b. KIND OF BUSINESS/INDUSTRY N/A	
17. FATHER'S NAME (First, Middle, Last) ROBERT HENDERSON, JR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) JANET MASON			
19a. INFORMANT'S NAME (Type/Print) JANET HENDERSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1526 STONEWOOD ROAD/BALTIMORE, MARYLAND 21239			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY		DATE		20c. LOCATION — City or Town, State CATONSVILLE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dorothy K. Jones</i>				22. NAME AND ADDRESS OF FACILITY WM.C.MARCH F.H./1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HYPOTHERMIA COMPLICATING ACUTE ETHANOL INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) FOUND: 3-4-94		28b. TIME OF INJURY FOUND: 4:43 P M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND: WOODED AREA				28e. DESCRIBE HOW INJURY OCCURRED SUBJECT EXPOSED TO WEATHER			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4900 HILLEN ROAD BALTIMORE, MARYLAND							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) MARCH 05/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAR 08 1994				32. REGISTRAR'S SIGNATURE <i>John Benison-Russell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



6



94 06860

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Helen Athelia Hampe				2. DATE OF DEATH MONTH March 6, DAY 1994 YEAR		3. TIME OF DEATH 10:10 P. M	
4. SOCIAL SECURITY NUMBER 219-10-1005		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-5-1906	
9a. FACILITY NAME (If not institution, give street and number) Holly Hill Manor				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Towson		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 531 Stevenson Lane				10f. ZIP CODE 21286		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) George Franklin Devilbiss				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rachel Helena Wareheim			
19a. INFORMANT'S NAME (Type/Print) R. Norman Hampe				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Overpark Court, Baltimore, Maryland 21234			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial Park		DATE		20c. LOCATION — City or Town, State Parkville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wallace S. Brooks Jr.				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cerebrovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER D-17041		29d. DATE SIGNED (Month, Day, Year) 7 Mar 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marc Leavey, M.D. 7600 Osler Drive, Towson, Maryland 21204							
31. DATE FILED (Month, Day, Year) MAR 08 1994				32. REGISTRAR'S SIGNATURE John Andrew Rindell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH		REG. NO. 94 06861			
1. DECEDENT'S NAME (First, Middle, Last) Adelaide R. Healy				2. DATE OF DEATH MONTH DAY YEAR 3/4/1994				3. TIME OF DEATH 9:15 P.M.					
4. SOCIAL SECURITY NUMBER 216-82-9143		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 11/19/1911			
8. BIRTHPLACE (State or Foreign Country) MD				9a. FACILITY NAME (If not institution, give street and number) 6020 FOXHALL MANOR DRIVE				9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE		9c. COUNTY OF DEATH BALTIMORE			
10a. STATE MD		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION CATONSVILLE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 6020 FOXHALL MANOR DRIVE				10f. ZIP CODE 21228				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME									
17. FATHER'S NAME (First, Middle, Last) HERMAN F. LUCKE				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE MAISEL									
19a. INFORMANT'S NAME (Type/Print) ROBERT F. HEALY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6020 FOXHALL MANOR DRIVE, CATONSVILLE, MD. 21228									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery 3/8/1994		20c. LOCATION — City or Town, State BALTIMORE, MD									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY 1630 EDMONDSON AVENUE CATONSVILLE, MD. 21228									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. <i>Cardiomyopathy</i> DUE TO (OR AS A CONSEQUENCE OF): t. <i>Alzheimer's Disease</i> DUE TO (OR AS A CONSEQUENCE OF): u. DUE TO (OR AS A CONSEQUENCE OF): v. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death 1 yr 6 yrs.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D05596		29d. DATE SIGNED (Month, Day, Year) 3/15/94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
31. DATE FILED (Month, Day, Year) MAR 08 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>									


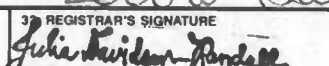


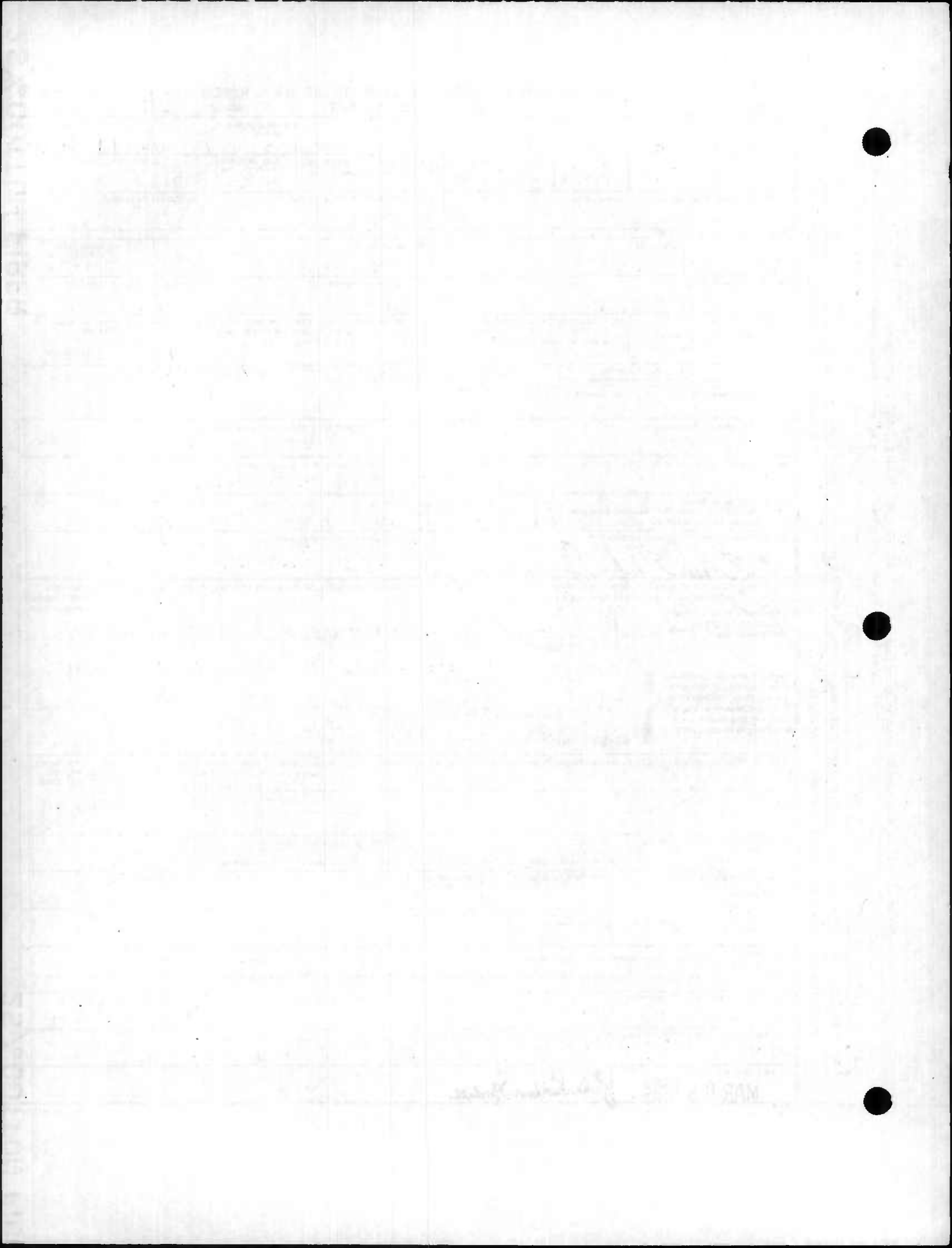
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO. 94 06862							
1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES E HARRIS</b>								2. DATE OF DEATH MONTH <b>3</b> DAY <b>1</b> YEAR <b>94</b>				3. TIME OF DEATH <b>11:20 PM</b>							
4. SOCIAL SECURITY NUMBER <b>217-26-1141</b>				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-2-1925</b>		8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>									
9a. FACILITY NAME (If not institution, give street and number) <b>BON SECOUR HOSPITAL</b>								9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH							
10a. STATE <b>MD</b>				10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>1014 POPLAR GROVE ST.</b>								10f. ZIP CODE <b>21216</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>AFR. AMERICAN</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				15b. KIND OF BUSINESS/INDUSTRY											
17. FATHER'S NAME (First, Middle, Last) <b>EDGAR HARRIS</b>								18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CORA VIRGINIA HARRIS</b>											
19a. INFORMANT'S NAME (Type/Print) <b>JANIE HARRIS</b>								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1014 POPLAR GROVE ST. BALTIMORE, MD 21216</b>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation — <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARBUTUS MEM. PARK 3/8/94</b>				20c. LOCATION — City or Town, State <b>ARBUTUS, MD</b>											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 								22. NAME AND ADDRESS OF FACILITY <b>ESTEP BROTHERS FUNERAL P.A. 1300 EUTAW PLACE BALTIMORE, MD 21217</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do NOT enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Possible Pulmonary Embolism</b> <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div> <b>Chronic obstructive Pulmonary disease</b>  <b>Hypertension, Diabetes</b>  <b>History of Asbestosis</b> </div> </div>												Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED									
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Suresh K. Tripathi</b>								29c. LICENSE NUMBER <b>D30661</b>				29d. DATE SIGNED (Month, Day, Year) <b>3/2/94</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SURESH K. TRIPATHI Bon Secours Hospital 2000 W. Baltimore, Md - 21223</b>																			
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE 															



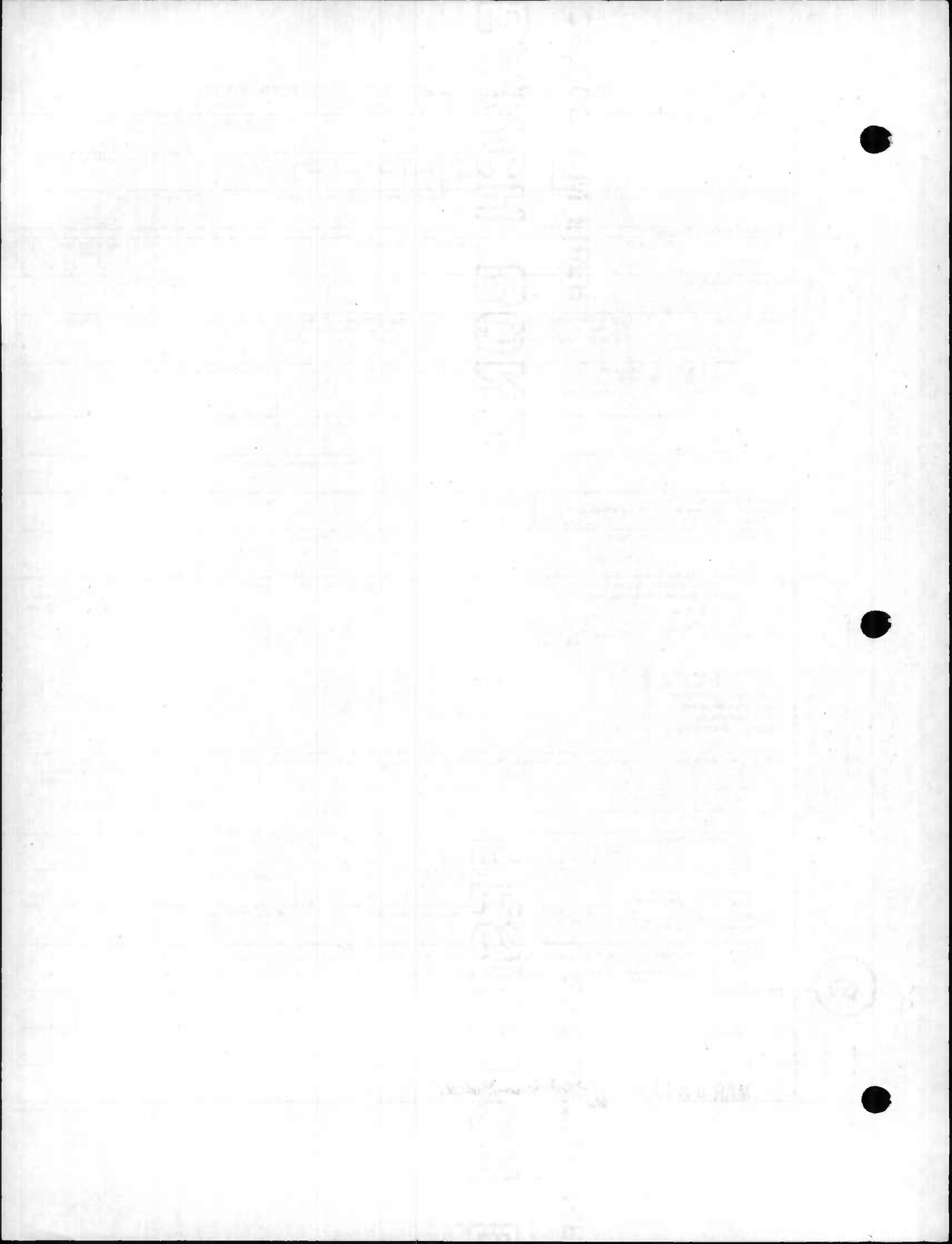


TO THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMMEDIATE IF ITEM 28 IS MARKED, OR ITEM 23 SHOWS ANY INJURY, OR OTHER TRAUMATIC EVENT, THE MEDICAL EXAMINER MUST BE NOTIFIED AT ONCE.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH		REG. NO. 96 06863	
1. DECEDENT'S NAME (First, Middle, Last) Elsie M. JAMSEN						2. DATE OF DEATH MONTH DAY YEAR MARCH 5, 1994		3. TIME OF DEATH 12:35 P. M.			
4. SOCIAL SECURITY NUMBER 214-30-2644		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 76 YRS.	7. DATE OF BIRTH (Month, Day, Year) OCT. 17, 1917	8. BIRTHPLACE (State or Foreign Country) MARYLAND						
9a. FACILITY NAME (If not institution, give street and number) 270 Shakespeare Drive				9b. CITY, TOWN OR LOCATION OF DEATH Severna Park		9c. COUNTY OF DEATH Anne Arundel					
10a. STATE MARYLAND						10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION SEVERNA PARK		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 270 SHAKESPEARE DRIVE				10f. ZIP CODE 21146		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OFFICE WORK		15b. KIND OF BUSINESS/INDUSTRY BANKING							
17. FATHER'S NAME (First, Middle, Last) OSCAR SALMI				18. MOTHER'S NAME (First, Middle, Maiden Surname) ADA LARSON							
19a. INFORMANT'S NAME (Type/Print) LINDA CARNAGGIO				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 270 SHAKESPEARE DRIVE - SEVERNA PARK, MD. 21146							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY		DATE 2/7		20c. LOCATION — City or Town, State BALTIMORE					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 Wilkens Avenue Baltimore, MD 21229							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Oro-pharyngeal carcinoma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. SIGNATURE AND TITLE OF CERTIFIER MD		29c. LICENSE NUMBER D22689		29d. DATE SIGNED (Month, Day, Year) Mar 5, 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. K. Viswanathan 692A Ritchie Hwy - Severna Park, MD											
31. DATE FILED (Month, Day, Year) MAR 08 1994		32. REGISTRAR'S SIGNATURE Julia Davidson-Rodell									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				94 06864			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) <b>Dorothy Lee Johnson</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 3, 1994</b>		3. TIME OF DEATH M <b>M</b>					
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) YRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>830 W. 32nd Street</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH					
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>3331 Elm Avenue</b>				10f. ZIP CODE <b>21211</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+) <b>Book Binder</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Book Binder</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Book Binding</b>							
17. FATHER'S NAME (First, Middle, Last) <b>William Myers</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Gladys Rhodes</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Charles Johnson, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>830 W. 32nd Street, Baltimore, Md. 21211</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith 3/7</b>		20c. LOCATION — City or Town, State <b>Fullerton, Maryland</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James H. Carpenter</i>		22. NAME AND ADDRESS OF FACILITY <b>Burgee-Henss Funeral Home 21211</b> <b>3631 Falls Road, Baltimore, Maryland</b>									
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cancer of Liver</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Approximate Interval Between Onset and Death <b>6 Mo</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard L. Diamond</i>		29c. LICENSE NUMBER <b>D23076</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-4-94</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Richard Diamond 3730 Falls Road, Baltimore, Maryland 21211</b>				31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <i>John Anderson</i>			



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06865

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT KIRBY</b>				2. DATE OF DEATH MONTH <b>MAR.</b> DAY <b>1</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>7:45 PM</b>	
4. SOCIAL SECURITY NUMBER <b>213-32-7318</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>59</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 23, 1934</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>FALLSTON GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>FALLSTON</b>		9c. COUNTY OF DEATH <b>HARFORD</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Belair, Maryland</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>2050 Stratton Court</b>				10f. ZIP CODE <b>21015</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>15</b> College (1-4 or 5+) <b></b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>File Editor</b>		15b. KIND OF BUSINESS/INDUSTRY <b>U.S. Information Agency</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Hugh Lewis Kirby</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Theresa Campbell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Helen A. Kirby</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2050 Stratton Court Belair, Md. 21015</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Stanislaus Cemetery 3/5/94</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b></b>				22. NAME AND ADDRESS OF FACILITY <b>E. F. LASSAHN FUNERAL HOME 11750 Belair Road Kingsville, Md. 21087</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrest</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  <b>Ischemic Heart Disease</b>  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Joseph Penberell</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>3/2/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				94 06866							
CERTIFICATE OF DEATH				REG. NO.											
1. DECEDENT'S NAME (First, Middle, Last) John Kurica				2. DATE OF DEATH MONTH 3 DAY 4 YEAR 1994				3. TIME OF DEATH 8:09 p <sup>M</sup>							
4. SOCIAL SECURITY NUMBER 213-09-0549		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 4 16 1911		8. BIRTHPLACE (State or Foreign Country) New York					
9a. FACILITY NAME (If not institution, give street and number) Francis Scott Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH							
RESIDENCE OF DECEDENT															
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Dundalk				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER Berkshire Road 7600				10f. ZIP CODE 21224				10g. CITIZEN OF WHAT COUNTRY? United States							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES X		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 6 College (1-4 or 5+) 6		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Pipe Fitter				15b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel									
17. FATHER'S NAME (First, Middle, Last) Steve Kurica				16. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Gavarria											
19a. INFORMANT'S NAME (Type/Print) Mary Ann Kowalewski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Twin Oak Road 1815 Jarrettsville Md. 21084											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn 3/7		20c. LOCATION — City or Town, State Baltimore, Maryland											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark A. Pysach</i>				22. NAME AND ADDRESS OF FACILITY W. Dabrowski/Chojnacki F.H. P.A. 1005 Dundalk Ave. Balto., Md. 21224											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypertensive Cardio Vascular Disease DUE TO (OR AS A CONSEQUENCE OF): b. Sepsis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cg. of bladder. Old CVA										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED							
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER <i>Atthysian</i>		29c. LICENSE NUMBER D14618		29d. DATE SIGNED (Month, Day, Year) 3-7-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BIENVENIDO R MATOS, M.D. 21 CRANFROOK Rd BALTIMORE, MD 21031															
31. DATE FILED (Month, Day, Year) MAR 08 1994				32. REGISTRAR'S SIGNATURE <i>John Sandom-Rudolph</i>											



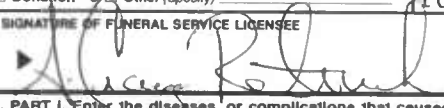
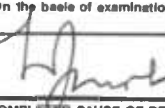
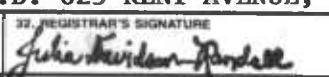


1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06867

1. DECEDENT'S NAME (First, Middle, Last) <b>ELINOR ELAINE KESSEL</b>				2. DATE OF DEATH MONTH DAY YEAR <b>02 28 1994</b>		3. TIME OF DEATH <b>04:55</b> M	
4. SOCIAL SECURITY NUMBER <b>577-40-9211</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 8 1921</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND, MD.</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>WV</b>		10b. COUNTY <b>Mineral</b>		10c. CITY, TOWN OR LOCATION <b>Keyser</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1065 Florida Avenue</b>				10f. ZIP CODE <b>26726</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Homemaker</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Leslie Evans</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nellie V. Foley</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Lawrence Kessel</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1320 Quarry Ridge Road Cumberland, MD 21502</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Potomac Memorial Gardens 3/2/94</b>		20c. LOCATION — City or Town, State <b>Keyser, WV 26726</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Rotruck-Smith Funeral Home 85 South Main Street Keyser, WV 26726</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Idiopathic Pulmonary Fibrosis</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>cerebral edema</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>DR. SUNIL GUPTA, M.D.</b>				29c. LICENSE NUMBER <b>D33280</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/1/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. SUNIL GUPTA, M.D. 625 KENT AVENUE, CUMBERLAND, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020  
THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06868

1. DECEDENT'S NAME (First, Middle, Last) <b>Leone J. Leight</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>5</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>1:00 PM</b>	
4. SOCIAL SECURITY NUMBER <b>217-20-3253</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 31 1924</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Key Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>Pennsylvania</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Dundalk</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7915 St. Bridget Lane</b>				10f. ZIP CODE <b>21222</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>10th</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Ira Long</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen Emma Biddle</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Donna J. Miller</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4038 Lyndale Ave. Baltimore, MD 21213</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Alttop Service Corp. 3/7/94</b>		20c. LOCATION — City or Town, State <b>Towson, MD</b>		20d. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>Parkinson's Disease</b> DUE TO (OR AS A CONSEQUENCE OF):							
d. _____							
23. PART II. Enter the conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension, Osteoarthritis</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER <b>L1418</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/5/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Stephen Villone John Hopkins Hospital 600 N Wolfe St Baltimore MD 21205</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE REGISTRAR: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



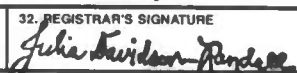


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO. 94 06869							
1. DECEDENT'S NAME (First, Middle, Last) Martha Chloe LIGHT								2. DATE OF DEATH MONTH DAY YEAR Feb 27 1994				3. TIME OF DEATH 6:37 P M							
4. SOCIAL SECURITY NUMBER 214-16-2749				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) OCT. 2, 1921		8. BIRTHPLACE (State or Foreign Country) CUMBERLAND, MD					
9a. FACILITY NAME (If not institution, give street and number) 1141 Courtney Road								9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH Baltimore							
RESIDENCE OF DECEDENT																			
10a. STATE MARYLAND				10b. COUNTY BALTIMORE				10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 1141 COURTNEY ROAD								10f. ZIP CODE 21227				10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 YEAR				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ADVERTISER				15b. KIND OF BUSINESS/INDUSTRY NEWSPAPER											
17. FATHER'S NAME (First, Middle, Last) CHARLES ROWAN								16. MOTHER'S NAME (First, Middle, Maiden Surname) PEARL TRUE											
19a. INFORMANT'S NAME (Type/Print) ROBIN PARK FULLER								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1141 COURTNEY ROAD - BALTIMORE, MD. 21227											
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY				DATE 3/3		20c. LOCATION — City or Town, State BALTIMORE									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 								22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 Wilkens Ave, Baltimore, MD 21229											
23. PART I: Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>COPD Respiratory Arrest</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>COPD</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST												Approximate interval between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED									
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER 								29c. LICENSE NUMBER D17821				29d. DATE SIGNED (Month, Day, Year) 3/1/94							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Warren Ross 1801 Dorsey Hall Drive, Suite 201 Columbia MD																			
31. DATE FILED (Month, Day, Year) MAR 08 1994				32. REGISTRAR'S SIGNATURE 															



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06870

1. DECEDENT'S NAME (First, Middle, Last) Rose M. Lombardi				2. DATE OF DEATH MONTH DAY YEAR March 3, 1994				3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <del>219-20-5846</del>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 27, 28		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 2 Churchberry Court				9b. CITY, TOWN OR LOCATION OF DEATH Reisterstown				9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Reisterstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2 Churchberry Ct.				10f. ZIP CODE 21136		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) Teachers Aide				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teachers Aide		16b. KIND OF BUSINESS/INDUSTRY Baltimore City Schools			
17. FATHER'S NAME (First, Middle, Last) Paul Muffoletto				18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Glorioso					
19a. INFORMANT'S NAME (Type/Print) Mr. Michael Lombardi				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Churchberry Ct. Reisterstown, MD 21136					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Memorial 3-7		20c. LOCATION — City or Town, State Cockeysville, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John K. Byers</i>				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC SMALL CELL CARCINOMA OF LUNG DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 4 mos.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul A. Neri MD</i>				29c. LICENSE NUMBER MD 043939		29d. DATE SIGNED (Month, Day, Year) 3/4/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 600 N. WOLFE ST BALTIMORE MD 21287									
31. DATE FILED (Month, Day, Year) MAR 08 1994				32. REGISTRAR'S SIGNATURE <i>John D. Anderson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Vol. 100, No. 1

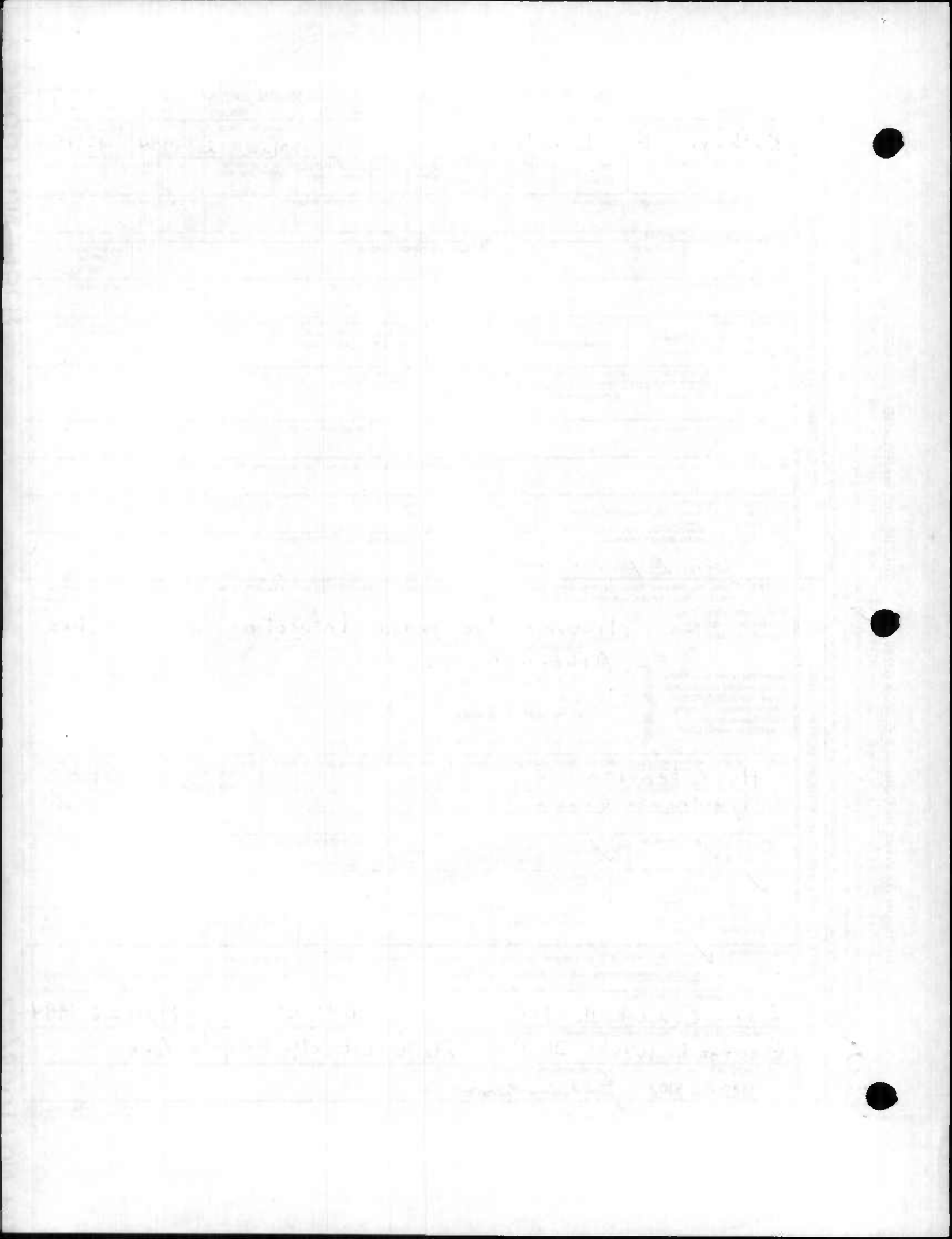


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				94 06871			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) <b>Kathryn G. Loveless</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Mar 2 1994</b>		3. TIME OF DEATH <b>12:15 P.M.</b>					
4. SOCIAL SECURITY NUMBER <b>216-14-3048</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>86</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>July 23, 1907</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Liberty Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>Baltimore City</b>					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore City</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>2549 Pickwick Rd.</b>				10f. ZIP CODE <b>21207</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (8-12)</b> <b>12 years</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Stenographer</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Baltimore Life Insurance</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Charles William Grove</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie Haughey</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Kathryn L. Kemp</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7406 Arden Rd. Cabin John, MD 20818</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lorraine Park Cemetery</b>		20c. LOCATION — City or Town, State <b>13-5 Woodlawn, MD</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>John K. Ayres</b>				22. NAME AND ADDRESS OF FACILITY <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133</b>							
23. PART I: Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Probable Myocardial Infarction</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>b. Atherosclerosis</b> <b>c.</b> <b>d.</b>								Approximate Interval Between Onset and Death <b>3hrs</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>Myasthenia Gravis</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>George E. Wicks III M.D.</b>				29c. LICENSE NUMBER <b>D41365</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 2, 1994</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>George E. Wicks III M.D. 2600 Liberty Heights Ave.</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <b>John T. Anderson-Randall</b>							



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06872

1. DECEDENT'S NAME (First, Middle, Last) <b>CARRIE LEWIS</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>2</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>9:48</b> M					
4. SOCIAL SECURITY NUMBER <b>218-22-4048</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>99</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12 / 1 / 1895</b>		8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Irvington Knolls</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>			9c. COUNTY OF DEATH				
10a. STATE <b>MD</b>				10b. COUNTY			10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>11 S. Athol Avenue</b>				10f. ZIP CODE <b>21229</b>			10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>black</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>school teacher</b>			16b. KIND OF BUSINESS/INDUSTRY				
17. FATHER'S NAME (First, Middle, Last) <b>William Dunston</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Harriet Dunston</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Carrie B. Long</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>827 N. Arlington Avenue, Balto., MD 21217</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Zion 3/7/94</b>			20c. LOCATION — City or Town, State <b>Lansdowne, MD</b>						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Albert P. Wylie F/H 638 N. Gilmore St., Balto., MD 21217</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Multiple decubiti</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Hypoproteinemia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Dementia</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>6 months</b> <b>6 months</b> <b>10 yrs</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST											
PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I. <b>Chronic Renal Failure</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Amaten N. Haern M.D.</b>				29c. LICENSE NUMBER <b>D15503</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/1994</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>501 DOLPHIN STREET, BALTIMORE MD 21217</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Informant: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06873

1. DECEDENT'S NAME (First, Middle, Last) <b>Elise May Moyer</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>3</b> YEAR <b>94</b>		3. TIME OF DEATH <b>6:20 A M</b>							
4. SOCIAL SECURITY NUMBER <b>213-58-3201</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-6-02</b>		8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Randallstown</b>				9c. COUNTY OF DEATH <b>Baltimore</b>					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Randallstown</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>10900 Liberty Road</b>				10f. ZIP CODE <b>21133</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>-</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>							
17. FATHER'S NAME (First, Middle, Last) <b>David Miller</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unknown</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Joseph F. Moyer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10900 Liberty Rd Randallstown, MD 21133</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lake View Memorial Park 3/5/94</b>		DATE <b>3/5/94</b>		20c. LOCATION — City or Town, State <b>Sykesville, Maryland</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>John K. Sheldahl</b>				22. NAME AND ADDRESS OF FACILITY <b>Loring Byers Funeral Directors, INC. 8728 Liberty Rd Randallstown, MD 21133-4784</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Stroke</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death <b>1 month</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>M B PARMAN</b>								29c. LICENSE NUMBER <b>D13899</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-3-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>M B PARMAN 5700 OLD WENT RD</b>													
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>		32. REGISTRAR'S SIGNATURE <b>John D. Anderson</b>											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				94 06874									
CERTIFICATE OF DEATH				REG. NO.													
1. DECEDENT'S NAME (First, Middle, Last) <b>FANNIE MARTIN</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>6</b> YEAR <b>94</b>				3. TIME OF DEATH <b>7:20A M</b>									
4. SOCIAL SECURITY NUMBER <b>219-70-5571</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>43</b> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 MRS. HOURS _____ MIN. _____		7. DATE OF BIRTH (Month, Day, Year) <b>5/28/50</b>		8. BIRTHPLACE (State or Foreign Country) <b>DELAWARE</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>CHURCH HOSP CORP / 100 N BROADWAY BALTO MD 21231</b>								9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTO MD.</b>				9c. COUNTY OF DEATH <b>BALTO</b>					
RESIDENCE OF DECEDENT																	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
10e. STREET AND NUMBER <b>1837 AIKEN ST.</b>				10f. ZIP CODE <b>21213</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>				16b. KIND OF BUSINESS/INDUSTRY									
17. FATHER'S NAME (First, Middle, Last) <b>UNKNOWN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>UNKNOWN</b>													
19a. INFORMANT'S NAME (Type/Print) <b>FABIAN &amp; ROBERT JACKSON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1837 AIKEN ST. BALTIMORE, MD. 21213</b>													
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GREENMOUNT CEMETERY</b>				DATE <b>3/10</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>BETTS FUNERAL HOME</b> <b>1129 N. CAROLINE ST. BALTO, MD 21213</b>													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RENAL FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												Approximate interval between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>GANGLIENE (E) ROOT.</b>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>NO INJURY</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>								29c. LICENSE NUMBER <b>D18977</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/6/94</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)																	
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>													





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06875

1. DECEDENT'S NAME (First, Middle, Last) <b>JOSEPHINE CATHERINE MONTAGNA</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>7</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>2:30 A</b> M	
4. SOCIAL SECURITY NUMBER <b>215-30-3637</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 23, 1909</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>GOOD SAMARITAN NURSING CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8715 MARAVOSS LANE</b>				10f. ZIP CODE <b>21234</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		15b. KIND OF BUSINESS/INDUSTRY <b>AT HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>VINCENT FARACE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ROSE SCALCO</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ROSEMARY STARTT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8715 MARAVOSS LANE BALTIMORE, MD. 21234</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>DULANEY VALLEY CEM. 3/9/94</b>		20c. LOCATION — City or Town, State <b>TOWSON, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Dolan</i> <b>JOHN E. DOLAN</b>		22. NAME AND ADDRESS OF FACILITY <b>LEONARD J. RUCK INC. 5305 HARFORD ROAD BALTIMORE, MD. 21214</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinoma of cecum</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>malnutrition</b> <b>pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Carcinoma of cecum</b> b. <b>malnutrition</b> c. <b>pneumonia</b> d. <b></b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE NOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gail Wilson Miller</i>		29c. LICENSE NUMBER <b>022719</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/7/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. GAIL WILSON - MILLER 5601 LOCH RAVEN BLVD. BALTIMORE, MD.</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>		32. REGISTRAR'S SIGNATURE <i>Gail Wilson Miller</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06876

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WINIFRED L. MAXSON</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>07</b> YEAR <b>94</b>		3. TIME OF DEATH <b>5:25 A.</b> M	
4. SOCIAL SECURITY NUMBER <b>235-32-5338</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>01-26-19</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1919 OLD FREDERICK ROAD</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CATONSVILLE</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>CATONSVILLE</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>1919 OLD FREDERICK ROAD</b>			
10f. ZIP CODE <b>21228</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SECRETARY</b>		16b. KIND OF BUSINESS/INDUSTRY <b>INSURANCE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ELVA MAXSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MINNIE JONES</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MIRIAM ECKMAN (SISTER)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1919 OLD FREDERICK ROAD CATONSVILLE MARYLAND 21228</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PINE GROVE CEMETERY 03/10/94</b>		20c. LOCATION — City or Town, State <b>BEREA, WEST VIRGINIA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>LEROY M &amp; RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>primary amyloidosis</i> DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> <b>Charles St. Amos</b>				29c. LICENSE NUMBER <b>D07249</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/7/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>EMILE R. MCHELER JR STANES N. 900 CATON AVE BALTO MD 21229</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06877

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES C. MASSEY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>03 06 94</b>		3. TIME OF DEATH HOURS MINUTES <b>05:37 AM</b>	
4. SOCIAL SECURITY NUMBER <b>263-10-1609</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>03-29-07</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>		8c. COUNTY OF DEATH <b>A.A. COUNTY</b>	
9a. STATE <b>MARYLAND</b>		9b. COUNTY <b>ANNE ARUNDEL</b>		9c. CITY, TOWN OR LOCATION <b>GLEN BURNIE</b>		9d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
9e. STREET AND NUMBER <b>7355 FURNACE BRANCH ROAD E.</b>				9f. ZIP CODE <b>21060</b>		9g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CLERICAL WORKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>RAIL ROAD</b>			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) <b>ARTHUR DRAGER (ATTORNEY)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 LIGHT STREET BALTIMORE MARYLAND 21202</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GOOD SHEPHERD CEMETERY 03/08/94</b>		20c. LOCATION — City or Town, State <b>ELLICOTT CITY, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>LEROY M &amp; RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <i>Cardiorespiratory arrest</i> DUE TO (OR AS A CONSEQUENCE OF):  b. <i>Acute respiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF):  c. <i>Aspiration</i> DUE TO (OR AS A CONSEQUENCE OF):  d.  Approximate Interval Between Onset and Death <i>1 hour</i> <i>1 hour</i> <i>1-2 hours</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		26c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26d. DESCRIBE HOW INJURY OCCURRED		26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.				29c. LICENSE NUMBER <b>D25000</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 6, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PO-HSLU HUNG, M.D./325 HOSPITAL DRIVE, #108/GLEN BURNIE, MARYLAND 21061</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

RECEIVED

EXHIBIT

RECEIVED

EXHIBIT

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

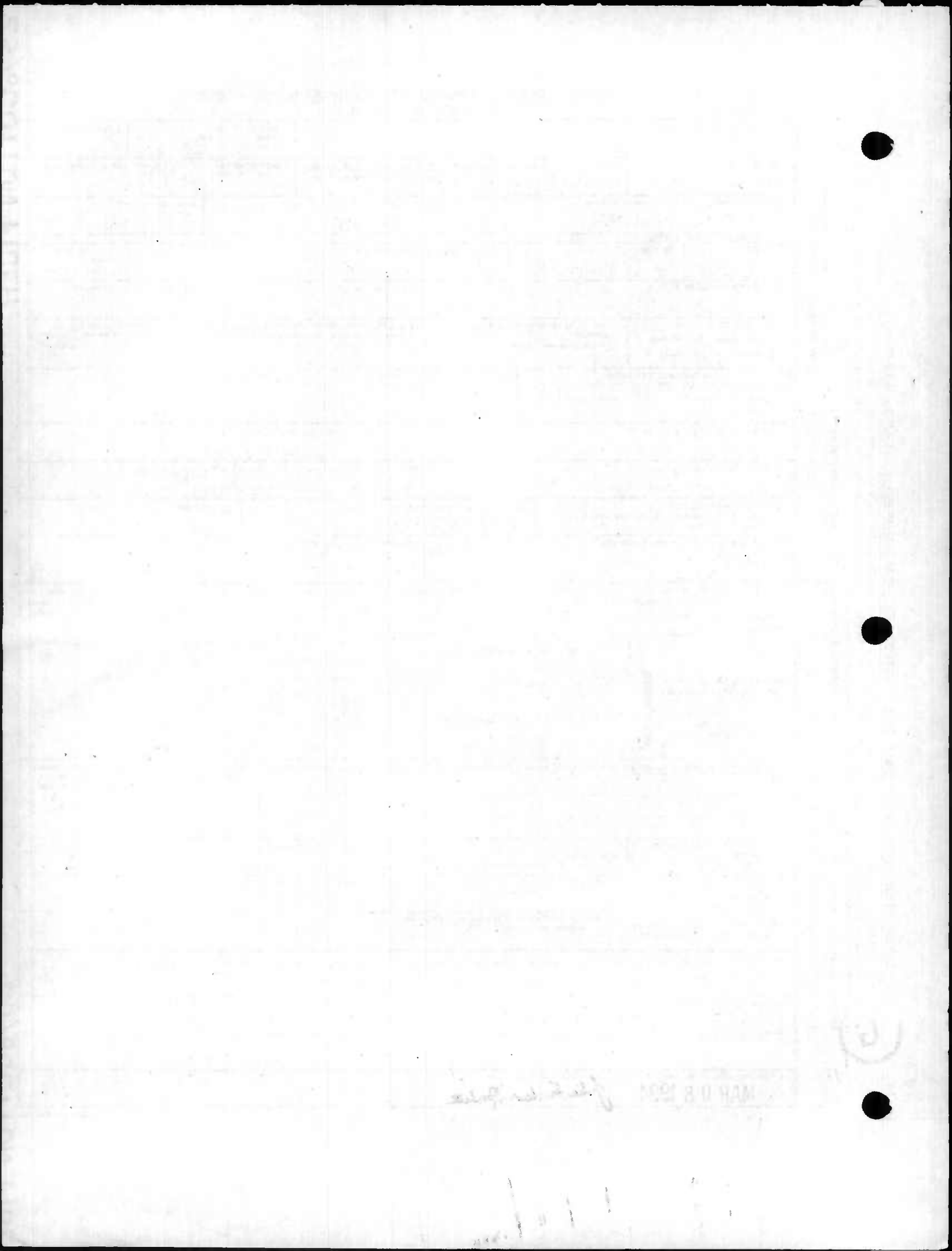
REG. NO.

94 06878

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) DOROTHY B. MANGOLD				2. DATE OF DEATH MONTH DAY YEAR MARCH 02, 1994		3. TIME OF DEATH 1:10 P. M.			
4. SOCIAL SECURITY NUMBER 219-40-8969		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 01, 1908		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) 5532 CARVILLE AVENUE				9b. CITY, TOWN OR LOCATION OF DEATH ARBUTUS			9c. COUNTY OF DEATH BALTIMORE		
RESIDENCE OF DECEDENT									
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION ARBUTUS			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 5532 CARVILLE AVENUE				10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9TH GRADE College (13-16) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER			16b. KIND OF BUSINESS/INDUSTRY HOMEMAKING		
17. FATHER'S NAME (First, Middle, Last) HARRY A. ENGEL				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET B. SQUIRES					
19a. INFORMANT'S NAME (Type/Print) MRS. SHERRY VOLKMAR				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1026 HARTMONT ROAD - CATONSVILLE, MD. 21228					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY 3/5			20c. LOCATION — City or Town, State BALTIMORE				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kevin P. Smith</i>				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE - BALTIMORE, MD. 21229					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Ovarian Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death <i>2 yrs</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. C. C. Waterfield</i>				29c. LICENSE NUMBER D24356		29d. DATE SIGNED (Month, Day, Year) 3/2/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. WILLIAM C. WATERFIELD - ONCOLOGY DEPARTMENT - 900 S. CATON AVE - BALTO., MD 21229									
31. DATE FILED (Month, Day, Year) MAR 08 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06879

1. DECEDENT'S NAME (First, Middle, Last) <del>MARIE</del> Sadie M. NICHOLSON				2. DATE OF DEATH MONTH DAY YEAR 02 26 94		3. TIME OF DEATH 11:30 PM M	
4. SOCIAL SECURITY NUMBER 218-01-0726		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 96 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 12, 1897	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. COUNTY OF DEATH A.A. COUNTY			
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH A.A. COUNTY	
10a. STATE Maryland		10b. COUNTY Anne Arundel Co.		10c. CITY, TOWN OR LOCATION Hanover		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7143 Wright Rd.				10f. ZIP CODE 21076		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Tecumseh Burley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Johnson			
19a. INFORMANT'S NAME (Type/Print) Louis M. Matthews				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1681 Preakness Drive Gambrills, Maryland 21054			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Saints Rest Cemetery 12/4		20c. LOCATION — City or Town, State Harmans, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Herbert E. Nutter	
22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto., MD. 21216							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive heart failure due to right side pneumonia due to viral infection due to arterio-sclerotic heart disease Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Hypertension & atherosclerosis							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER D02583		29d. DATE SIGNED (Month, Day, Year) 2/27/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) ANASTACIO E. SUBONG, M.D./206 CRAIN HIGHWAY, SW/GLEN BURNIE, MD 21061							
31. DATE FILED (Month, Day, Year) MAR 08 1994		32. REGISTRAR'S SIGNATURE Julia Davidson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Evelyn Ella Nagle				2. DATE OF DEATH MONTH March DAY 4, 1994 YEAR		3. TIME OF DEATH 11:40 P. M.			
4. SOCIAL SECURITY NUMBER 214-18-3365		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 12, 1922			
9a. FACILITY NAME (If not institution, give street and number) Medbridge Nursing & Convalescent Center				9b. CITY, TOWN OR LOCATION OF DEATH Rosedale		9c. COUNTY OF DEATH Baltimore County			
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION Rosedale		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10a. STATE Md.		10b. COUNTY Baltimore County		10e. STREET AND NUMBER 6600 Ridge Road		10f. ZIP CODE 21237			
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Coding Clerk		16b. KIND OF BUSINESS/INDUSTRY Social Security AdM.			
17. FATHER'S NAME (First, Middle, Last) Joseph Nagle				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Gilda					
19a. INFORMANT'S NAME (Type/Print) Evelyn M. Bruno				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6411 Ridgeview Avenue Baltimore, Md. -21206					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Memorial 3-7		20c. LOCATION — City or Town, State Timonium Balto. Co.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Kathleen M. Murphy			
22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. Baltimore, Md. -21206		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. ASPIRATED PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): b. CEREBROVASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]			
29c. LICENSE NUMBER 123967		29d. DATE SIGNED (Month, Day, Year) 3/5/94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CESAR G. GARCIA MD 3400 ISLEMAN RD. BALTIMORE		31. DATE FILED (Month, Day, Year) MAR 08 1994			
32. REGISTRAR'S SIGNATURE [Signature]		33. REGISTRAR'S SIGNATURE [Signature]		34. REGISTRAR'S SIGNATURE [Signature]		35. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06881

1. DECEDENT'S NAME (First, Middle, Last) <b>Kolley E. Overstreet SR.</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>05</b> YEAR <b>94</b>		3. TIME OF DEATH <b>840 A M</b>	
4. SOCIAL SECURITY NUMBER <b>216101517</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08/26/16</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>GOOD SAMARITAN</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8130 OAKLEIGH ROAD</b>				10f. ZIP CODE <b>21234</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SALESMAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OIL</b>			
17. FATHER'S NAME (First, Middle, Last) <b>OSCAR W. OVERSTREET</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY F. MOORE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JUDY A. MAZZACCARO</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2401 BRADLEY DRIVE HARRISBURG, PA. 17110</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MORELAND MEMORIAL CEM.</b>		DATE <b>3/8/94</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>John E. Dolan</b>				22. NAME AND ADDRESS OF FACILITY <b>LEONARD J. RUCK INC. 5305 HARFORD ROAD BALTIMORE, MD. 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>renal failure, bilateral deep vein thrombosis</b>							
c. <b>chronic CHF, chronic atrial fibrillation, aortic + mitral regurgitation</b>							
d. <b>regurgitation</b>							
Approximate Interval Between Onset and Death <b>1d</b> <b>1/94</b> <b>yrs</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Alan Kimmel MD</b>				29c. LICENSE NUMBER <b>D25783</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/7/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Alan Kimmel 220 W. Cold Spring Lane 21210</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOSEPH GEORGE PAYER</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>5</b> YEAR <b>94</b>		3. TIME OF DEATH <b>7:10 P M</b>	
4. SOCIAL SECURITY NUMBER <b>190 14 6722</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3/6/21</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>ST. AGNES HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>CATONSVILLE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6122 MT. RIDGE ROAD</b>				10f. ZIP CODE <b>21228</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>3</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MANAGEMENT ANALYST</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. GOVERNMENT</b>			
17. FATHER'S NAME (First, Middle, Last) <b>STEPHEN A. PAYER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA MATSKO</b>			
19a. INFORMANT'S NAME (Type/Print) <b>VERNA PAYER</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6122 MT. RIDGE ROAD BALTIMORE MD. 21228</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ALL SAINTS CEMETERY</b>		20c. LOCATION — City or Town, State <b>3/10/94 ELYSBURG PA.</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Russell Witzke</i>				22. NAME AND ADDRESS OF FACILITY <b>LEROY RUSSELL WITZKE FUNERAL HOME 1630 EDMONDSON AVE. BALTO. MD. 21228</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Gastric Cancer with metastasis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. throughout ABDOMINAL (carcinomatous)</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James H. Blum</i> / MD				29c. LICENSE NUMBER <b>D32319</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/5/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Raymond Plack MD 3449 Wilkens Ave Baltimore MD 21229</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





ML

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06883

1. DECEDENT'S NAME (First, Middle, Last) <b>ANTWAIN ROBERTS</b>				2. DATE OF DEATH MONTH <b>FEB.</b> DAY <b>27</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>12:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>212-08-7908</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>9</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-22-84</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>2035 HOLLINS STREET</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>MD</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2035 HOLLINS ST.</b>				10f. ZIP CODE <b>21223</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary <input checked="" type="checkbox"/> (0-12) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>JACKIE ROBERTS, SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>TYRLETT GOOD</b>			
19a. INFORMANT'S NAME (Type/Print) <b>PHYLLIS ROUZER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>700 E. 41ST ST. BALTIMORE, MD 21218</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>DULANEY VALLEY MEM 3/4</b>		20c. LOCATION — City or Town, State <b>COCKEYSVILLE, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>BETTS FUNERAL HOME 1129 N. CAROLINE ST. BALT, MD 21213</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SMOKE INHALATION</b> DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>02/26/94</b>		28b. TIME OF INJURY <b>11:41 P</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED <b>VICTIM OF A HOUSE FIRE</b>				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>2035 HOLLINS STREET</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB. 27, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ML  
94-0974-510

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06884

1. DECEDENT'S NAME (First, Middle, Last) SEAIRA ROBERTS				2. DATE OF DEATH FEB 27 1994		3. TIME OF DEATH 12:30					
4. SOCIAL SECURITY NUMBER 218-11-2149		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 7 YRS.		7. DATE OF BIRTH 03-25-86		8. BIRTHPLACE (State or Foreign Country) MD			
9a. FACILITY NAME (If not institution, give street and number) 2035 HOLLINS STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH				
RESIDENCE OF DECEDENT				10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 2035 HOLLINS ST.		10f. ZIP CODE 21223		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) JACKIE ROBERTS, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) TYRLETTE GOOD							
19a. INFORMANT'S NAME (Type/Print) PHYLLIS ROUZER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 E. 41ST. BALTIMORE, MD. 21218							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DULANEY VALLEY MEM 3/4		20c. LOCATION — City or Town, State COCKEYSVILLE, MD.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Guillermo Comas</i>				22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOME 1129 N. CAROLINE ST. BALTIMORE, MARYLAND 21213							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SMOKE INHALATION DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO INSPECTION		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 2/26/1994		28b. TIME OF INJURY 11:41P		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED VICTIM OF A HOUSE FIRE	
28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) HOME				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2035 HOLLINS STREET							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Margie M. Krell</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) FEB 27, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) MAR 08 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							



94-0975-510

UNK 94-35

BKK

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06885

1. DECEDENT'S NAME (First, Middle, Last) <b>NIKITA</b>				2. DATE OF DEATH MONTH <b>FEB</b> DAY <b>27</b> YEAR <b>1994</b>				3. TIME OF DEATH <b>0030 A M</b>	
4. SOCIAL SECURITY NUMBER <b>218-23-8790</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>5</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-30-88</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>2035 HOLLINS ST.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE <b>md.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTO.</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1631N. GAY ST.</b>				10f. ZIP CODE <b>21213</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Child</b>		15b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Kevin Brown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Henritte Rouzer</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Phyllis Rouzer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7005 41st St. BALTO. MD. 21218</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulany Mem. Garden</b>		DATE <b>2/27/94</b>		20c. LOCATION — City or Town, State <b>BALTO. MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>PATRICIA BEETS E</b>				22. NAME AND ADDRESS OF FACILITY <b>1129 N. CAROLINE ST</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>SMOKE INHALATION</b> DUE TO (OR AS A CONSEQUENCE OF):									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
b. DUE TO (OR AS A CONSEQUENCE OF):									
c. DUE TO (OR AS A CONSEQUENCE OF):									
d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO <b>DISSECTION</b>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>02-26-1994</b>		28b. TIME OF INJURY <b>2341 M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT VICTIM OF FIRE</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>2035 HOLLINS ST</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>BALTIMORE CITY</b>	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Henritte Rouzer</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB 27, 1994</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARYANN H. WILSON 111 Penn Street, Baltimore, Maryland 21201</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Pendell</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06886

1. DECEDENT'S NAME (First, Middle, Last) <b>DIONTA</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB. 27 1994</b>				3. TIME OF DEATH A M <b>0030 A</b>	
4. SOCIAL SECURITY NUMBER <b>None</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS <b>17 11 17</b>		7. DATE OF BIRTH (Month, Day, Year) <b>7-26-93</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>2035 HOLLINS STREET</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH	
10a. STATE <b>md</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTO</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1631 N. GAY ST</b>				10f. ZIP CODE <b>21213</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Child</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Jessie Scott</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Henaritte Rowzer</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Phyllis Rowzer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>700 E 41st St. BALTO. MD. 21218</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulany Mem Garden 3/4 BALTO. MD</b>		20c. LOCATION — City or Town, State <b>BALTO. MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Betts Funeral Home Patricia Bitt</b>				22. NAME AND ADDRESS OF FACILITY <b>1129 N. CAROLINE ST</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>SMOKE INHALATION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>INSPECTION</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>FEB. 26, 1994</b>		28b. TIME OF INJURY <b>2341</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED <b>VICTIM OF A HOUSE FIRE</b>	
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) <b>HOME</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>2035 HOLLINS STREET</b>					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Margie M. Krell</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB. 27, 1994</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

JOHN H. HARRIS  
JUNE 11 24 27. BATH. WY. 91918



94-0976-510  
UNK 94-36  
BKK

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06887

1. DECEDENT'S NAME (First, Middle, Last) <b>ELDRIDGE</b>				2. DATE OF DEATH MONTH <b>FEB</b> DAY <b>27</b> YEAR <b>1994</b>				3. TIME OF DEATH <b>0030 A M</b>			
4. SOCIAL SECURITY NUMBER <b>220-25-4877</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>4</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-16-89</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>2035 HOLLINS ST.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH			
RESIDENCE OF DECEDENT											
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTO</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>1631 N. GAY ST</b>				10f. ZIP CODE <b>21213</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (14 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Child</b>				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>James Seemay</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Henriette Rouzer</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Phyllis Rouzer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>700 E. 41st St. BALTO. MD 21217</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dunkley Mem Gardens 3/4 BALTO MD</b>				20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>PATRICIA BETTS</b>				22. NAME AND ADDRESS OF FACILITY <b>1129 N. Caroline St</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>SMOKE INHALATION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>Inspection</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>02-26-1994</b>		28b. TIME OF INJURY <b>2341 M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT VICTIM OF FIRE</b>	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>2035 HOLLINS ST.</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>BALTIMORE CITY</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Monique MacKule</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>				29d. DATE SIGNED (Month, Day, Year) <b>FEB 27, 1994</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>HARRISON A. KORON MD 111 Penn Street, Baltimore, Maryland 21201</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94-0978-510

UNK 94-38

BKK

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06888

1. DECEDENT'S NAME (First, Middle, Last) <b>JACKIE ROBERTS JR.</b>				2. DATE OF DEATH MONTH <b>FEB</b> DAY <b>27</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>0030 A M</b>	
4. SOCIAL SECURITY NUMBER <b>219-34-9330</b>		5. SEX <b>XX M 2 F</b>		6. AGE (In yrs. last birthday) <b>1 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>02-12-93</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD</b>				9. COUNTY OF DEATH <b>BALTIMORE CITY</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>2035 HOLLINS ST.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>			
10a. STATE <b>MD</b>				10b. COUNTY <b>BALTIMORE</b>			
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>2035 HOLLINS ST.</b>				10f. ZIP CODE <b>21223</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (9-12)</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>JACKIE ROBERTS, SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>TYRLETTE GOOD</b>			
19a. INFORMANT'S NAME (Type/Print) <b>PHYLLIS ROUZER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>700 E. 41st st. BALTIMORE MD. 21218</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>DULANEY VALLEY MEM 3/4</b>		20c. LOCATION — City or Town, State <b>COCKEYSVILLE, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Betts Funeral Home/Patricia Bitts</b>				22. NAME AND ADDRESS OF FACILITY <b>1129 N. Caroline St</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SMOKE INHALATION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>INSPECTED</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				27a. DATE OF INJURY (Month, Day, Year) <b>02-26-1994</b>		27b. TIME OF INJURY <b>2341 M</b>	
27c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				27d. DESCRIBE NOW INJURY OCCURRED <b>SUBJECT OF HOUSE FIRE</b>			
27e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>2035 HOLLINS ST.</b>				27f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>BALTIMORE CITY</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Wynne Mackell</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB 27, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Maryanne N. KOREN 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Rodale</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06889

1. DECEDENT'S NAME (First, Middle, Last) <b>Elsie M. Robins</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 03 1994</b>		3. TIME OF DEATH <b>3:10 A M</b>	
4. SOCIAL SECURITY NUMBER <b>577-60-5236</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86 92 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>August 27, 1907</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Wilson Health Care Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Gaithersburg</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Gaithersburg</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>211 Russell Ave.</b>			
10f. ZIP CODE <b>20877</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 8+) <input checked="" type="checkbox"/> <b>1</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Civil Service Air Force</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Louis Mielke</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Martha Schroder</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Robert Lippy</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11 Valley Path Cockeysville, Md. 21030</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Druid Ridge Cemetery 3/5/94</b>		20c. LOCATION — City or Town, State <b>Pikesville, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Donald C. Schlegel</b>				22. NAME AND ADDRESS OF FACILITY <b>1050 York Rd. 21204 Ruck Towson Funeral Home, Inc.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cerebrovascular accident</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. Cerebral arteriosclerosis</b> c. _____ d. _____ OUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death <b>2 days</b> <b>5 years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> _____ 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>James R. Moore Jr. MD</b>					
		29c. LICENSE NUMBER <b>07231</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-3-94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James R. Moore Jr. 207 Brookes Ave Gaithersburg Md. 20877</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

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RECEIVED

RECEIVED

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06890

1. DECEDENT'S NAME (First, Middle, Last) <b>Richard Carroll Reed Sr.</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>5<sup>th</sup></b> YEAR <b>94</b>		3. TIME OF DEATH <b>4:15 A M</b>				
4. SOCIAL SECURITY NUMBER <b>194-20-9299</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3/24/26</b>		8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Stella Maris Hospice</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>			9c. COUNTY OF DEATH <b>Baltimore</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>2903A Cold Stream Way</b>				10f. ZIP CODE <b>21234</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1943-1947</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 6+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Salesman</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Department Store</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Carroll L. Reed</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jeanetta Moore</b>						
19a. INFORMANT'S NAME (Type/Print) <b>Richard C. Reed Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4413 Necker Avenue Baltimore, MD 21236</b>						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 03/07</b>		DATE <b>Baltimore, MD 21228</b>		20c. LOCATION — City or Town, State				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>George E. MacNabb</b>				22. NAME AND ADDRESS OF FACILITY <b>Cremation Society of Md., Inc. 299 Frederick Rd. Baltimore, MD 21228</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cancer of lung</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. metastatic Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Kendall R. Faulkner M.D.</b>				29c. LICENSE NUMBER <b>D25643</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 5<sup>th</sup> 94</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Kendall R. Faulkner, M.D. 2300 Dulany Valley Rd. Towson, MD 21204</b>										
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>		32. REGISTRAR'S SIGNATURE <b>John B. ...</b>								

NEW YORK BOOM

SAVED BY THE

NEW YORK BOOM

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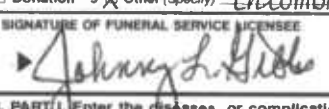
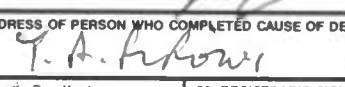



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06891

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles S. RIMEL, Sr.</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>4</b> YEAR <b>94</b>		3. TIME OF DEATH <b>11:00 a m</b>	
4. SOCIAL SECURITY NUMBER <b>232-26-2222</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-11-1921</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Middle River</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3706 Holly Grove Road</b>				10f. ZIP CODE <b>21220</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II Navy</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th Grade</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Pennsylvania Rail Road</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Herman H. Rimel</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dora Hixenbaugh</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Charles Rimel, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3706 Holly Grove Road Middle River, MD 21220</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Druid Ridge Mem. Gdns 3/7/94</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>		20d. DATE <b>3/7/94</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Possible Acute MI</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Due to (or as a consequence of):</b> <b>Congenital aortic valve disease</b> b. <b>Due to (or as a consequence of):</b> <b>Congenital aortic valve disease</b> c. <b>Due to (or as a consequence of):</b> <b>Congenital aortic valve disease</b> d. <b>Due to (or as a consequence of):</b> <b>Congenital aortic valve disease</b>  Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>DLY 221</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-7-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. A. Brown 223 E. Blvd BALT MD 21221</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HUSBAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06892

1. DECEDENT'S NAME (First, Middle, Last) <i>Richard B. Robb</i>				2. DATE OF DEATH MONTH DAY YEAR <i>3 7 94</i>		3. TIME OF DEATH <i>0015 AM</i>			
4. SOCIAL SECURITY NUMBER <i>205-12-2566</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>72</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>1/31/1922</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>University of Maryland</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		9c. COUNTY OF DEATH			
10a. STATE <i>Md.</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Towson</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <i>1106 Ryegate Rd.</i>				10f. ZIP CODE <i>21286</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>9 Mar. 1945-25 Nov. 1945</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5+</i> College (1-4 or 5+) <i>5+</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Metallurgical Engineer</i>		16b. KIND OF BUSINESS/INDUSTRY <i>U.S. Steel</i>					
17. FATHER'S NAME (First, Middle, Last) <i>Claude Robb M.D.</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Philomen BeDour</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Mary Robb</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Same as 10e</i>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Hilltop Service Corp. 3/8/94</i>		20c. LOCATION — City or Town, State <i>Towson, Md.</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Ruck Towson Funeral Home Inc. 1050 York Rd. Towson, Md. 21204</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sepsis</i> a. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>relapse of acute myelogenous leukemia</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>atrial fibrillation</i> <i>chronic renal insufficiency</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas F. Watter</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>3/7/94</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
31. DATE FILED (Month, Day, Year) <i>MAR 08 1994</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					


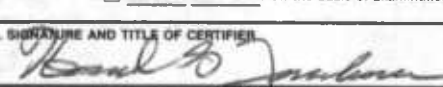



ITEM: 1. PER F.H. FILM G-709 3/8/94 t.t

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06893

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY ELLEN RILEY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>03 03 94</b>		3. TIME OF DEATH <b>11:30 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>217-01-8369</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 18, 1907</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Westminster Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Westminster</b>	
9c. COUNTY OF DEATH <b>Carroll</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Carroll</b>				10c. CITY, TOWN OR LOCATION <b>Westminster</b>			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>2246 Ridge Road</b>			
10f. ZIP CODE <b>21157</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>10th grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Office</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Sterling Eugene Yingling</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Ella Boon</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Bill J. Riley, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>32 Henry Ave. Baltimore, MD 21236</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>		DATE <b>3/7</b>		20c. LOCATION — City or Town, State <b>Parkville, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic kidney cancer</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D17040</b>		29d. DATE SIGNED (Month, Day, Year) <b>03-04-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Howard C. Lanham, M.D. 215 Washington Hgts Med Ctr, Westminster MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06894

1. DECEDENT'S NAME (First, Middle, Last) <b>James Rylands</b>				2. DATE OF DEATH MONTH DAY YEAR <b>3-4-94</b>		3. TIME OF DEATH <b>10:30 p m</b>	
4. SOCIAL SECURITY NUMBER <b>217-03-8656</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4/26/06</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Mercy Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>611 S. Charles Street</b>				10f. ZIP CODE <b>21230</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>steel worker</b>		15b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>unknown</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>arthur Drager</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 Light St. Baltimore, MD suite 510, 21202</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Hill</b>		DATE <b>3/9/94</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Albert P. Wylie F/H</b> <b>638 N. Gilmore Street, Balto., MD 21211</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory failure</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <b>COPD</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>Congestive heart failure</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D 34974</b>		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>7154 cradle rock way Columbia MD 21045</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE MEDICAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06895

1. DECEDENT'S NAME (First, Middle, Last) Vincent Joseph Rattini				2. DATE OF DEATH MONTH DAY YEAR March 4, 1994		3. TIME OF DEATH P. M. 9					
4. SOCIAL SECURITY NUMBER 218-92-6923		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 23, 1922		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 7924 Langdon Lane				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH Baltimore			
10a. STATE Md.			10b. COUNTY Baltimore			10c. CITY, TOWN OR LOCATION			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 7924 Langdon Lane				10f. ZIP CODE 21206				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Superintendent		16b. KIND OF BUSINESS/INDUSTRY Whiting Turner Co.					
17. FATHER'S NAME (First, Middle, Last) Leonard Rattini				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carmella Marinella							
19a. INFORMANT'S NAME (Type/Print) Clementina R. Rattini				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7924 Langdon Lane Baltimore, Md. — 21206							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cem. 3-8		20c. LOCATION — City or Town, State Baltimore, Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kathleen R. Murphy				22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. 6415 Belair Road Baltimore, Md. — 21206							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HTV, DM, blood BKA								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Fernando Ferro M.D.						29c. LICENSE NUMBER D40480		29d. DATE SIGNED (Month, Day, Year) 3/7/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FERNANDO FERRO, M.D. 5910 BELAIR RD BALTO., MD 21206											
31. DATE FILED (Month, Day, Year) MAR 08 1994				32. REGISTRAR'S SIGNATURE John B. Riddle							



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06896

1. DECEDENT'S NAME (First, Middle, Last) <b>Nancy Shaw</b>			2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 5 94</b>		3. TIME OF DEATH <b>746 P M</b>
4. SOCIAL SECURITY NUMBER <b>229-12-5075</b>	5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>71</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>2-19-23</b>	8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Levindale</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH -----
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	10c. CITY, TOWN OR LOCATION <b>Catonsville</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER <b>401-B Shade Tree Place</b>			10f. ZIP CODE <b>21228</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Medical Office</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Harry Barnett Hall</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ethel Meade</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Elizabeth A. Goodwin</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3269 Sharp Road Glenwood, Maryland 21738</b>		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lorraine Pk. Cemetery 3/9</b>		20c. LOCATION — City or Town, State <b>Woodlawn, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>George E. MacNabb</b>			22. NAME AND ADDRESS OF FACILITY <b>MacNabb Funeral Home 301 Frederick Rd. Balto., MD 21228</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>b. Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Pressure Sore</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Debra S. Wertheimer MD</b>			29c. LICENSE NUMBER <b>D23767</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 6, 1994</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DEBRA S. WERTHEIMER 2434 W. Belvedere Ave. BALTO, MD 21215</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>			32. REGISTRAR'S SIGNATURE <b>John Anderson-Rudolph</b>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06897

1. DECEDENT'S NAME (First, Middle, Last) <b>Edith Barbara Bane Lacey-SMITH</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>4<sup>th</sup></b> YEAR <b>94</b>		3. TIME OF DEATH <b>1:10 AM</b>					
4. SOCIAL SECURITY NUMBER <b>212-26-8369</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 20 1904</b>		8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Good Samaritan Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>				9c. COUNTY OF DEATH <b>N/A</b>			
RESIDENCE OF DECEDENT											
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Phoenix</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>13408 Blythenia Road</b>				10f. ZIP CODE <b>21131</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>9</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Homemaking</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Thomas NMN Bane</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Evelyn Greene</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Barbara J. Tracey</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13408 Blythenia Road, Phoenix, MD 21131</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Grdns.</b>		DATE <b>Mar. 7, 1994</b>		20c. LOCATION — City or Town, State <b>Timonium, MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Martin D. Lawson</b>				22. NAME AND ADDRESS OF FACILITY <b>Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Road, Timonium, MD 21093</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>URO SEPSIS</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>ALZHEIMER'S DEMENTIA</b>  Approximate Interval Between Onset and Death <b>2 days</b> <b>9 years</b>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Sabbat MD</b>				29c. LICENSE NUMBER <b>P-07621</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 4<sup>th</sup> 94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Samer TABAR, MD, The Good Samaritan Hosp, 5601 Loch Raven Blvd, Baltimore, MD 21239</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <b>Johanna Davidson-Randall</b>							

RECEIVED

1900

RECEIVED

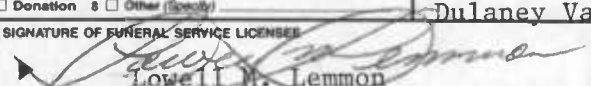
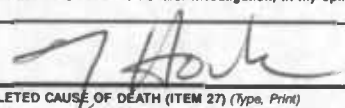
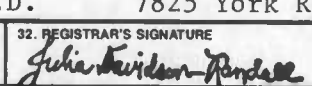
1900

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06898

1. DECEDENT'S NAME (First, Middle, Last) <b>Irby Garrison Sorrells</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 27 1994</b>		3. TIME OF DEATH <b>8:25 P. M.</b>	
4. SOCIAL SECURITY NUMBER <b>259-09-8728</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 03, 1915</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Manor Care-Towson Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>TOWSON</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>509 E. Joppa Rd.</b>				10f. ZIP CODE <b>21204</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W.II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Dentist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Dental Health</b>			
17. FATHER'S NAME (First, Middle, Last) <b>James Hill Sorrell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Susie Maynor</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Garry Sorrells</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O.Box 127, Glen Arm, MD 21057</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Gardens</b>		20c. LOCATION — City or Town, State <b>Timonium, MD</b>		20d. DATE <b>3</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>Lowell M. Lemmon</b>				22. NAME AND ADDRESS OF FACILITY <b>Lemmon-Mitchell-Wiedefeld, Inc., 10 W. Padonia Rd., Timonium, MD 21093</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. sepsis, unknown etiology</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d.</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHF</b> <b>CHF</b> <b>Pulmonary emboli</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Theodore Houk, M.D.</b>				29c. LICENSE NUMBER <b>D41104</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-28-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Theodore Houk, M.D. 7825 York Road, Towson, MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE FUNERAL HOME OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

STANDARD

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1950

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

96 06899

1. DECEDENT'S NAME (First, Middle, Last) <b>Ursula Margaret SAMS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 5, 1994</b>		3. TIME OF DEATH M <b>8:58 P</b>	
4. SOCIAL SECURITY NUMBER <b>233 30 1891</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 18, 1906</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>		8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Middle River</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3703 White Pine Road</b>				10f. ZIP CODE <b>21220</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Edward Nolan</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Carrie V. Smith</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sharon Shehan</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9 Duralumin Court Baltimore, Md. 21220</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or crematorium) <b>Oak Lawn Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore County, Md.</b>		DATE <b>3/9/94</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Bruzdinski Funeral Home PA 1407 Eastern Ave. Baltimore, Md. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>a. Ruptured Aortic Aneurysm</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>044040</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/8/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Kimberlynn Richards, MD 9000 Franklin Square Drive Baltimore, MD 21237</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

July 18, 1906 (cont. from p. 1)

July 18, 1906 (cont. from p. 1)

Forville

Forville (cont. from p. 1)

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Forville (cont. from p. 1)

ITEMS: 1. 10g, PER F.H. FILM G-709 3/8/94 t.t

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06900

1. DECEDENT'S NAME (First, Middle, Last) BETTY MAE SAULSBERRY				2. DATE OF DEATH MONTH DAY YEAR MARCH 4, 1994		3. TIME OF DEATH 10:10 a.m.	
4. SOCIAL SECURITY NUMBER 213-28-7341		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07-04-35	
9a. FACILITY NAME (If not institution, give street and number) MARYLAND GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH BALTIMORE CITY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2620 GREENMOUNT AVENUE				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married Sep 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 TH College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TEACHER'S ASSISTANT		16b. KIND OF BUSINESS/INDUSTRY MIDTOWN CHILDREN CENTER			
17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) HATTIE DANCE			
19a. INFORMANT'S NAME (Type/Print) MARY FINCH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2620 GREENMOUNT AVENUE, BALTIMORE, MD 21218			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) VOSHALL MEMORIAL GARDEN 03-09 DUNDALK, MARYLAND		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephanie K. Jones</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.- 1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → MYOCARDIAL INFARCTION							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR DISEASE DIABETES END-STAGE RENAL DISEASE							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Khosrow Tabassi</i> House staff				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) March 4-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KHOSROW TABASSI, M.D. c/o MARYLAND GENERAL HOSPITAL							
31. DATE FILED (Month, Day, Year) MAR 08 1994				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) <b>Charles Lawrence Soelch</b>			2. DATE OF DEATH MONTH <b>March</b> DAY <b>4</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>9:53 P.M.</b>
4. SOCIAL SECURITY NUMBER <b>213-36-5498</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>77</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>11-26-1916</b>	8. BIRTHPLACE (State or Foreign Country) <b>Connecticut</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Manor Care Ruxton Nursing Home</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>Ruxton</b>		9c. COUNTY OF DEATH <b>Baltimore</b>
RESIDENCE OF DECEDENT					
10a. STATE <b>Florida</b>	10b. COUNTY	10c. CITY, TOWN OR LOCATION <b>Delray Beach</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>636 Hummingbird Lane</b>		10f. ZIP CODE <b>33445</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII Navy</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Controller</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Naval Base, Orlando, Fl.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>UNKNOWN Soelch</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>UNKNOWN Wall</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Mrs Ann B. Behner</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3839 Blenheim Road, Phoenix, Maryland 21131</b>		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hilltop Service Corp. 3-7-94</b>		20c. LOCATION — City or Town, State <b>Towson, Maryland 21204</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Wallace S. Brooks Jr.</b>			22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Prostate Ca</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY <b>M</b>	26c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	26d. DESCRIBE HOW INJURY OCCURRED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>			29c. LICENSE NUMBER <b>D33897</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/7/94</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Robert J. Vissing, M.D. 4300 N. Charles Street, Baltimore, Maryland</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06902

1. DECEDENT'S NAME (First, Middle, Last) <b>Anna T. Stein</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 2 1994</b>		3. TIME OF DEATH <b>8:35 PM</b>	
4. SOCIAL SECURITY NUMBER <b>213 01 0471</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 13, 1901</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Germany</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Caton Manor Nursing Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Pasadena</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1303 Montclair Dr.</b>				10f. ZIP CODE <b>21122</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Domestic</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Geissler</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) <b>Virginia T. Nash</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>972 Tidewater Rd., Pasadena, MD 21122</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glen Haven Memorial Park 3/5/94</b>		DATE <b>3/5/94</b>		20c. LOCATION — City or Town, State <b>Glen Burnie, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen D. Schuman</i>				22. NAME AND ADDRESS OF FACILITY <b>McCully Funeral Home of Pasadena 3204 Mountain Rd., Pasadena, MD 21122</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Aspiration Pneumonia</b> Approximate Interval Between Onset and Death <b>1 hr</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M.D.</i>				29c. LICENSE NUMBER <b>D26307</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <i>John S. Anderson</i>			





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				94 06903			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) John Samuel				2. DATE OF DEATH MAY 2/25/94		3. TIME OF DEATH 5:28 AM					
4. SOCIAL SECURITY NUMBER 248 01 8938		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 7/5/17		8. BIRTHPLACE (State or Foreign Country) S.C.			
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			9c. COUNTY OF DEATH				
RESIDENCE OF DECEDENT											
10a. STATE MD.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER 38 N. Rosedale St.				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Afr. American				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY						
17. FATHER'S NAME (First, Middle, Last) Bejamin Samuel				18. MOTHER'S NAME (First, Middle, Maiden Surname) Noami Samuel							
19a. INFORMANT'S NAME (Type/Print) Gracie Felder				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 N. Rosedale St. Balto, MD. 21229							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. Zion 3/2/94		DATE		20c. LOCATION — City or Town, State Lansdowne, MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>L. C. Estep</i>				22. NAME AND ADDRESS OF FACILITY Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto. Md. 21217							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): b. Coronary heart disease DUE TO (OR AS A CONSEQUENCE OF): c. atherosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2. Peripheral vascular disease Peptic ulcer (duodenal ulcer disease)								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Chris Echeverre</i>									
		29c. LICENSE NUMBER DIP327				29d. DATE SIGNED (Month, Day, Year) 2/28/94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Moses Gebremariam 4660 Wilkens Ave 203 Balto 21229											
31. DATE FILED (Month, Day, Year) MAR 08 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>									

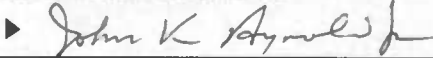
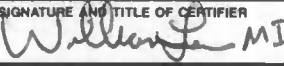
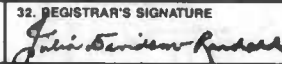


1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06904

1. DECEDENT'S NAME (First, Middle, Last) <b>JEAN HOFFMAN SELBY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 2, 1994</b>		3. TIME OF DEATH M <b></b>	
4. SOCIAL SECURITY NUMBER <b>219-20-8246A</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 1, 1926</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Carroll County General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Westminster</b>		9c. COUNTY OF DEATH <b>Maryland</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Carroll Co.</b>		10c. CITY, TOWN OR LOCATION <b>Sykesville</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>623 Old Liberty Rd.</b>				10f. ZIP CODE <b>21784</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 years</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Office Manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Robert M. Warfield, Inc.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>M. Duvall Hoffman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edith Hidey</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Albert Selby</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>623 Old Liberty Rd. Sykesville, MD 21784</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Wesley Freedom Cemetery</b>		DATE <b>3-5</b>		20c. LOCATION — City or Town, State <b>Eldersburg, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Rd. Winfield, MD 21784</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Emphysema, exacerbation of</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Emphysema</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b></b> DUE TO (OR AS A CONSEQUENCE OF): d. <b></b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death <b>hours</b> <b>years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>mitral valve prolapse, cardiac dysrhythmia</b> <b>gastroenteritis with mild dehydration</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY <b>M</b>		26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		26d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER <b>D34849</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/2/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William Tan, MD 1645 Liberty Rd Eldersburg MD 21784</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06905

1. DECEDENT'S NAME (First, Middle, Last) <b>CHADDIE MAE TOBIAS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 1, 1994</b>		3. TIME OF DEATH <b>7:15A M</b>					
4. SOCIAL SECURITY NUMBER <b>212-34-2179</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>05-30-25</b>		8. BIRTHPLACE (State or Foreign Country) <b>S.C.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>			9c. COUNTY OF DEATH				
RESIDENCE OF DECEDENT				10a. STATE <b>MD.</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>745 W. KINGSWAY RD.</b>		10f. ZIP CODE <b>21220</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10-12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>SIM ANDERSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SARAH UNKNOWN</b>							
19a. INFORMANT'S NAME (Type/Print) <b>WILLIE TOBIAS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>745 W. KINGSWAY R. BALTIMORE, MD 21220</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PINEY GROVE CHURCH CEM3/6</b>		20c. LOCATION — City or Town, State <b>CHESTER, S.C.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>BETTS FUNERAL HOME</b>				22. NAME AND ADDRESS OF FACILITY <b>1129 N. CAROLINE ST. BALTIMORE, MARYLAND 21213</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Severe obstructive pulmonary disease</b> <b>Severe ischemic cardiomyopathy</b>								Approximate Interval Between Onset and Death <b>~2 weeks</b> <b>~5 yrs</b> <b>~5 yrs</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>hypothyroid</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>DR. PEGMAN MD</b>						29c. LICENSE NUMBER <b>J5790</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/1/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DJ SPEGMAN MD 600 N. Wolfe St. JHH Baltimore MD</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>							

RICHA WOTTON

RECEIVED

RECEIVED

SEP 20 1965

SEP 20 1965

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06906

1. DECEDENT'S NAME (First, Middle, Last) <b>CATHERINE ELIZABETH TALBOTT</b>				2. DATE OF DEATH MONTH <b>Mar</b> DAY <b>8</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>9:22 am</b>	
4. SOCIAL SECURITY NUMBER <b>215-14-9971</b>		5. SEX <b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>81</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>12-10-1912</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Saint Joseph Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>FLORIDA</b>		10b. COUNTY <b>Florida</b>		10c. CITY, TOWN OR LOCATION <b>Daytona Beach</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>222 Venetian Way South</b>				10f. ZIP CODE <b>32127</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Roger Morgan</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Blanche Morgan Fenhagen</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William Crawford, Sr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>921 Breezewick Circle, Towson, Maryland 21286</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Grds. 3-9-94 Timonium, Maryland</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>LUNG CANCER</b> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <b>11/2 YR</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>SEPSIS POSSIBLE ANTIBIOTIC ASSOCIATED COLITIS</b> DUE TO (OR AS A CONSEQUENCE OF):				<b>2 DAYS</b>	
		c. <b>METABOTIC ACIDOSIS 2ND TO #1 AND #2</b> DUE TO (OR AS A CONSEQUENCE OF):				<b>2 DAYS</b>	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D21207</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/6/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FRANZ C. VELLA- CAMILLERI M.D., 827 LINDEN AVE. BALTIMORE, MD. 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.







HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				94 06907									
CERTIFICATE OF DEATH				REG. NO.													
1. DECEDENT'S NAME (First, Middle, Last) CATHERINE BLANCHE THOMPSON				2. DATE OF DEATH MONTH DAY YEAR MARCH 03, 1994				3. TIME OF DEATH 1:15 P M									
4. SOCIAL SECURITY NUMBER 214-20-0348		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) JAN. 15, 1921		8. BIRTHPLACE (State or Foreign Country) MARYLAND					
9a. FACILITY NAME (If not institution, give street and number) 12 S. BELLE GROVE ROAD				9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE				9c. COUNTY OF DEATH BALTIMORE									
RESIDENCE OF DECEDENT																	
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION CATONSVILLE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
10e. STREET AND NUMBER 12 S. BELLE GROVE ROAD				10f. ZIP CODE 21228				10g. CITIZEN OF WHAT COUNTRY? U.S.A.									
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6TH GRADE				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALESLADY				16b. KIND OF BUSINESS/INDUSTRY FARBERS DEPARTMENT STORE									
17. FATHER'S NAME (First, Middle, Last) RICHARD SMITH				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIAN THOMAS													
19a. INFORMANT'S NAME (Type/Print) ROBERT G. THOMPSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 S. BELLE GROVE ROAD - CATONSVILLE, MD. 21229													
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		DATE 3/7		20c. LOCATION — City or Town, State BALTIMORE											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert G. Thompson</i>				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE - BALTIMORE, MD. 21229													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Acute Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Coronary Atherosclerosis</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												Approximate interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic obstructive pulmonary disease</u>												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29b. SIGNATURE AND TITLE OF CERTIFIER <i>Barbara Socha, M.D.</i>		29c. LICENSE NUMBER D35609		29d. DATE SIGNED (Month, Day, Year) 3/3/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. BARBARA SOCHA - SUITE 108 - 516 ROLLING ROAD - CATONSVILLE, MD. 21228																	
31. DATE FILED (Month, Day, Year) MAR 08 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>													

RECEIVED

RECEIVED

RECEIVED

2

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06908

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>John K. White, Jr.</b>		2. DATE OF DEATH MONTH DAY YEAR <b>March 6, 1994</b>		3. TIME OF DEATH M <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>233-28-7473</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 3, 1922</b>		8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>		9. CITY, TOWN OR LOCATION OF DEATH <b>Dundalk</b>	
10. FACILITY NAME (If not institution, give street and number) <b>2409 Meadow Road</b>		11. COUNTY OF DEATH <b>Baltimore</b>		12. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
13. STATE <b>Maryland</b>		14. COUNTY <b>Baltimore</b>		15. CITY, TOWN OR LOCATION <b>Dundalk</b>	
16. STREET AND NUMBER <b>2409 Meadow Road</b>		17. ZIP CODE <b>21222</b>		18. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
19. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		20. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES <b>1942 - 1946</b>		21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>Wire Drawer</b>		23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Steel Company</b>		24. KIND OF BUSINESS/INDUSTRY <b>White</b>	
25. FATHER'S NAME (First, Middle, Last) <b>John Kennedy White</b>		26. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jane Schackley</b>		27. INFORMANT'S NAME (Type/Print) <b>Dorothy M. White</b>	
28. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holly Hill Mem. Gard. 2/8/94</b>		30. LOCATION — City or Town, State <b>Baltimore County, Md.</b>	
31. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		32. NAME AND ADDRESS OF FACILITY <b>Bruzdinski Funeral Home PA 1407 Eastern Avenue Essex, Maryland 21221</b>		33. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Metastasis BRAIN TUMOR - 8 months</b> <b>LUNG CARCINOMA - 1 year</b> <b>Sequitally ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>Recurrent Lung failure</b>	
34. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Recurrent Lung failure</b>		35. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		36. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
37. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		38. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		39. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
40. DATE OF INJURY (Month, Day, Year)		41. TIME OF INJURY M <b>M</b>		42. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
43. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		44. DESCRIBE HOW INJURY OCCURRED		45. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
46. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		47. SIGNATURE AND TITLE OF CERTIFIER <b>Sompathi Deank</b>		48. LICENSE NUMBER <b>D 16163</b>	
49. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)		50. DATE SIGNED (Month, Day, Year)		51. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>	
52. REGISTRAR'S SIGNATURE <i>[Signature]</i>		53. REGISTRAR'S SIGNATURE		54. REGISTRAR'S SIGNATURE	



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06909

1. DECEDENT'S NAME (First, Middle, Last) <b>MAJOR BENT WILLIAMS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 4, 1994</b>		3. TIME OF DEATH M <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>214-26-0667</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>61</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 5, 1932</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. FACILITY NAME (If not institution, give street and number) <b>Church Home Hospital</b>			
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>2733 East Preston Street</b>			
10f. ZIP CODE <b>21213</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th Grade</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Disabled Veteran</b>		17. KIND OF BUSINESS/INDUSTRY <b>U.S. Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George L. Williams</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Grace Brown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary Murphy/ Jackie Williams</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2733 East Preston St. Baltimore, MD 21213</b> <b>2300 Pinewood Ave Balto, MD</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MD Veteran Cem/Garrison Forest 3/1</b>		20c. LOCATION — City or Town, State <b>Owings Mills, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kenneth Parker</b>				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes, Inc.</b> <b>2501 Gwynns Falls Parkway</b> <b>Baltimore, Maryland 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiogenic shock</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Acute subendocardial myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Ischemic heart disease</b> DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus</b> <b>Chronic Depression</b> <b>Chronic Renal Failure</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Rubert Kahn MD</b>				29c. LICENSE NUMBER <b>D43349</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R. Kahn MD CHURCH HOSPITAL, Baltimore MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>		32. REGISTRAR'S SIGNATURE <b>John Anderson</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06910

1. DECEDENT'S NAME (First, Middle, Last) <b>ERNEST B. WALTON Sr.</b>				2. DATE OF DEATH MONTH <b>Feb</b> DAY <b>28</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>2 22 PM</b>	
4. SOCIAL SECURITY NUMBER <b>233-34-9481</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH MONTH <b>8</b> DAY <b>17</b> YEAR <b>1924</b>	
8. BIRTHPLACE (State or Foreign Country) <b>W. Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>418 E. Fort Ave.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto. City Md.</b>	
9c. COUNTY OF DEATH -----				10a. STATE <b>Maryland</b>			
10b. COUNTY -----				10c. CITY, TOWN OR LOCATION <b>Balto. City Md.</b>			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>418 E. Fort Ave.</b>			
10f. ZIP CODE <b>21230</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W.2</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: _____		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>5th. Grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mechanic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Domino Sugar Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Wiley V. Walton</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nellie A. Ward</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Linda Frampton</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>418 E. Fort Ave. Balto. Md. 21230</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glen Haven Mem. Park 3/3/94</b>		20c. LOCATION — City or Town, State <b>Glen Burnie, Md.</b>		20d. DATE <b>3/3/94</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Daniel A. Harbo</b>				22. NAME AND ADDRESS OF FACILITY <b>Balto. Md. 21230 McCully Funeral Home. 130 E. Fort Av</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Respiratory Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Metastasis of Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Metastasis of Liver + Lung</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Carcinoma Prostate</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>minutes</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) _____ 28b. TIME OF INJURY <b>M</b> 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED _____ 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) _____ 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) _____			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Robert C. Irwin MD</b>				29c. LICENSE NUMBER <b>D08980</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-1-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Robert C. Irwin MD 828 N. Eutaw St. Balto. Md 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <b>Paul Sanders-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1870-1871

Received of  
the Treasurer  
of the  
Board of  
Education

George W. H. H. H.

for the year ending 1871



94-1097-510

DWG

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06911

1. DECEDENT'S NAME (First, Middle, Last) ALPHONSO WOJCIECHOWSKI				2. DATE OF DEATH MONTH DAY YEAR MARCH 04 94		3. TIME OF DEATH 6:15A M	
4. SOCIAL SECURITY NUMBER 167-30-3726		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 53 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12 01 1940	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9. COUNTY OF DEATH			
9a. FACILITY NAME (If not institution, give street and number) 1720 COLE STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore City		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1720 Cole Street				10f. ZIP CODE 21223		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1965-66		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Shipping clerk		16b. KIND OF BUSINESS/INDUSTRY Ellicott Machine Corp.	
17. FATHER'S NAME (First, Middle, Last) Alfonso WOJCIECHOWSKI				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen WALACAZAGE			
19a. INFORMANT'S NAME (Type/Print) Gloria D. Wojciechowski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1720 Cole Street, Baltimore, MD 21223			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cem. Garrison Forest-MD Veterans 3/07		20c. LOCATION — City or Town, State Owings Mills, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David J. McDonald</i>				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 Wilkens Ave, Baltimore, MD 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>PARTY LIVER</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO <i>Person</i>
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence 5 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <i>Marjorie P. Korsh</i>				29b. LICENSE NUMBER O.C.M.E.		29c. DATE SIGNED (Month, Day, Year) MARCH 04/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARJORIE P. KORSH 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAR 08 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

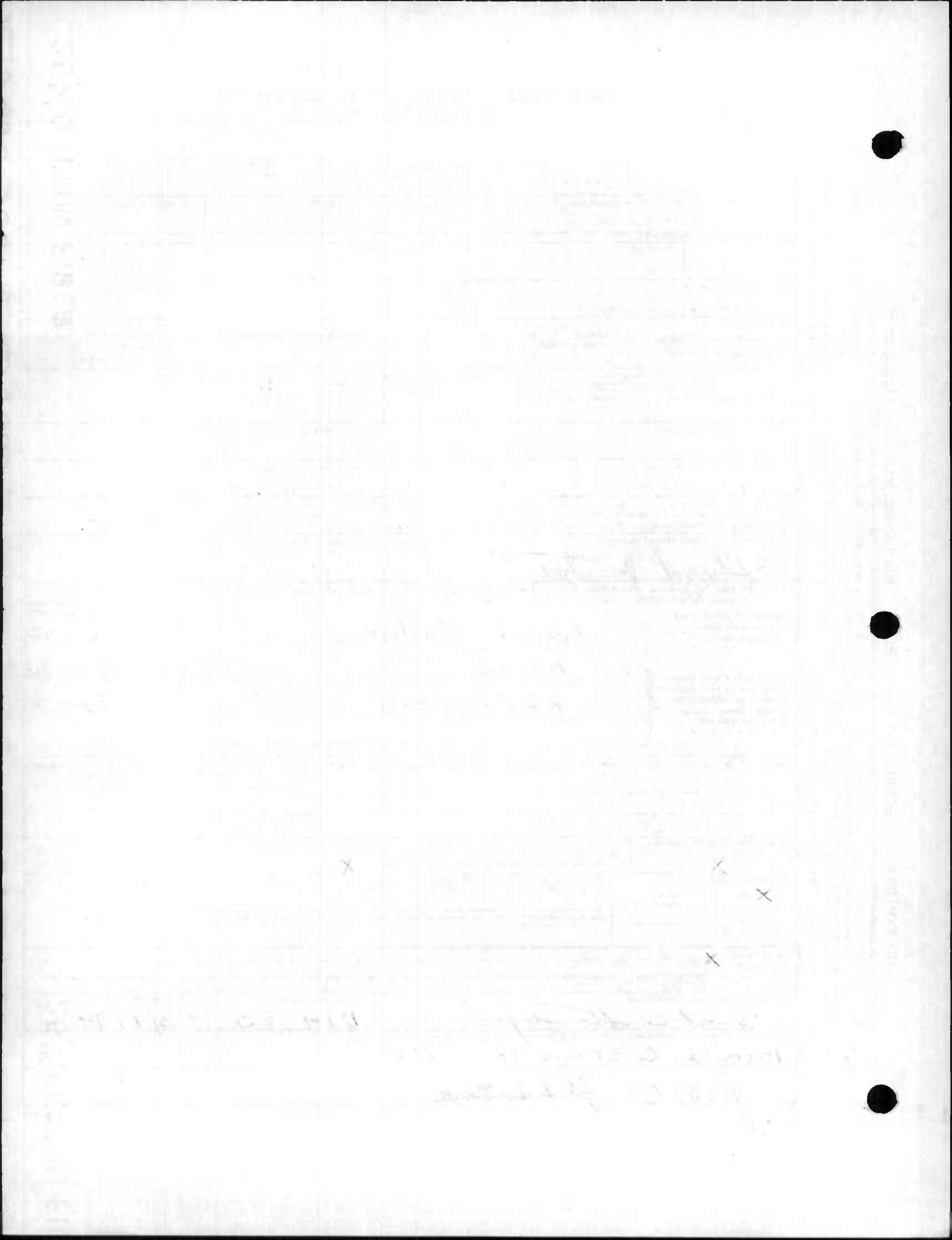


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



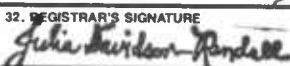
1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				94 06912	
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH	
REGINAL WATTS				MONTH DAY YEAR FEBRUARY 28, 1994				7:35 A. M.	
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)	
212-46-3827		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		YRS. MONTHS DAYS		9/12/48		MARYLAND	
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH	
4729 MELBOURNE ROAD				BALTIMORE					
RESIDENCE OF DECEDENT									
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?			
MARYLAND				BALTIMORE		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
4729 Melbourne Road				21229		USA			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.			
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 10/67 10/73		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		Specify: Afr. American			
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) College (1-4 or 5+)									
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)					
WALTER MILLER				ELIZABETH MITCHEL					
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Joyce Mitchel				4729 Melbourne Rd. Balto. MD. 21229					
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State			
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Garrison Forest 3/4/94				Owings Mills, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY					
				ESTEP BROTHERS FUNERAL SER, P.A. 1300 EUTAW PLACE, BALTIMORE, MD. 21217					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Renal Failure								2 months	
DUE TO (OR AS A CONSEQUENCE OF): b. AIDS								6 months	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST c. HIV Disease								3 years	
DUE TO (OR AS A CONSEQUENCE OF): d.									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one)					
				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED	
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)			
				D14383		3/1/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
Harold C Standiford M.D.									
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE					
MAR 08 1994									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				94 06913									
CERTIFICATE OF DEATH				REG. NO.													
1. DECEDENT'S NAME (First, Middle, Last) Eleanor Waters				2. DATE OF DEATH MONTH DAY YEAR 3/2/94				3. TIME OF DEATH 6:30 a m									
4. SOCIAL SECURITY NUMBER 216-24-0141		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 7/20/18		8. BIRTHPLACE (State or Foreign Country) MD.					
9a. FACILITY NAME (If not institution, give street and number) (Home) 1407 Ward St.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH									
RESIDENCE OF DECEDENT																	
10a. STATE MD.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO									
10e. STREET AND NUMBER 1407 Ward Street				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY? USA									
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Afr. American									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY											
17. FATHER'S NAME (First, Middle, Last) Charles Green				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucille Green													
19a. INFORMANT'S NAME (Type/Print) Carolyn Waters				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1407 Ward St. Balto, MD. 21230													
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Park 3/7/94		DATE		20c. LOCATION — City or Town, State Arbutus, MD.											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto. MD. 21217													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Metastatic colon carcinoma</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>lung cancer, HSD, ventricular</u>												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER 020040		29d. DATE SIGNED (Month, Day, Year) 3/3/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Gans MD, 700 Washington Blvd, Balto, Md 21230																	
31. DATE FILED (Month, Day, Year) MAR 08 1994				32. REGISTRAR'S SIGNATURE 													



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06914

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) Edna Marie WALLIS				2. DATE OF DEATH MONTH 3 DAY 1 YEAR 94		3. TIME OF DEATH 7:10 P M			
4. SOCIAL SECURITY NUMBER 212-62-7809		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 23, 1906		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville			9c. COUNTY OF DEATH Baltimore		
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Rosedale			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 9900 Philadelphia Rd.				10f. ZIP CODE 21237		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife			16b. KIND OF BUSINESS/INDUSTRY Homemaking				
17. FATHER'S NAME (First, Middle, Last) Charles H. Gunther				18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Freund					
19a. INFORMANT'S NAME (Type/Print) Doris Baverman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8809 Allenwood Rd. Randallstown, Md. 21133					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory Inc. 3-5-1994		20c. LOCATION — City or Town, State Baltimore, md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lassahn Funeral Home</i>				22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home 7401 Belair Rd. Balto., Md. 21236					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cerebrovascular accident</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Arteriosclerosis cerebrovas disease hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death <i>30 yrs</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Louis Semeroff MD</i>				29c. LICENSE NUMBER D10032		29d. DATE SIGNED (Month, Day, Year) 3/2/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23, Type, Print) LOUIS SEMEROFF MD 2108 CREMS RD BAL MD 21220									
31. DATE FILED (Month, Day, Year) MAR 08 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					









94-1024-021

ASP

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-709 3/11/94 t.t

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06916

1. DECEDENT'S NAME (First, Middle, Last) <b>OWEN D. WILSON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 01 1994</b>		3. TIME OF DEATH <b>2:50 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>316-10-4111</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 3, 1910</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>FREDERICK MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>		9c. COUNTY OF DEATH <b>FREDERICK</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Frederick</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1471 A2 Key Parkway</b>			
10f. ZIP CODE <b>21702-0163</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Army Officer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>United States Army</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Herbert Wilson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie Jared</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Christopher S. Wilson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3405 Mockingbird Ct., Ijamsville, Md. 21754</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Montgomery Crematory, Inc., 3/3/94</b>		20c. LOCATION — City or Town, State <b>Bethesda, Md.</b>		20d. DATE <b>3/3/94</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Olin L. Molesworth</b>				22. NAME AND ADDRESS OF FACILITY <b>Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. MULTIPLE BLUNT FORCE INJURIES COMPLICATED BY HYPOTHERMIA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>FOUND: 2-28-94</b>		28b. TIME OF INJURY <b>12:00 NOON</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT BEATEN AND EXPOSED TO COLD</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>FOUND: HOME</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1471 A2 KEY PARKWAY FREDERICK, MD. 21702</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 02, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20) (Type Print) <b>Amixor 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 23 is checked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06917

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>LOUIS O. WILSON</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>05</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>12:51 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>219-30-1207</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>59</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 13, 1934</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Good Samaritan Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Md.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1602 Wadsworth Way</b>				10f. ZIP CODE <b>21239</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1957-1959</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th Grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Home Improvement</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self Employed</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Frederick C. Wilson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Violet Craft</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Richard C. Wilson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>400 Idlewild Road Belair, Md.-21014</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Meadowridge Cem. 3-7</b>		20c. LOCATION — City or Town, State <b>ELkridge, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen A. Murphy</i>				22. NAME AND ADDRESS OF FACILITY <b>John C. Miller, Inc. 6415 Belair Road Baltimore, Md.-21206</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE MYOCARDIAL INFARCTION</b> Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death <b>ONE DAY</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Shalini M.D.</i>				29c. LICENSE NUMBER <b>026</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH, 05, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. SHALINI, GOOD SAMARITAN HOSPITAL, BALTIMORE,</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <i>John D. Anderson-Rudolf</i>			



94 06918

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EVELYN L. WILLIAMS</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>05</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>7:25 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>219-16-2944</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 3, 1918</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Good Samaritan Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>6116 Belair Road</b>	
10f. ZIP CODE <b>21206</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th Grade</b> College (1-4 or 8+) <b>Packer</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Packer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Morris &amp; Company</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Harry C. Lewis</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lulu Kobler</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jeanette M. Shrader</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4313 Parkwood Avenue, Baltimore, Maryland 21206</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>		20c. LOCATION — City or Town, State <b>3/8 Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kathleen M. Murphy</b>				22. NAME AND ADDRESS OF FACILITY <b>John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>SEPSIS</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → Approximate interval Between Onset and Death <b>TWO DAYS</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CONGESTIVE HEART FAILURE</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Shalini M.D.</b>			
29c. LICENSE NUMBER <b>016</b>				29d. DATE SIGNED (Month, Day, Year) <b>MARCH 05, 1994</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. SHALINI, GOOD SAMARITAN HOSPITAL, BALTIMORE, MARYLAND</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <b>John B. Rindler</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

THE NEW YORK PUBLIC LIBRARY

ASTEN LENOX TILDEN FOUNDATION

100 N. 5TH ST.

NEW YORK, N. Y.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06919

1. DECEDENT'S NAME (First, Middle, Last) <b>MARGARET ZAPF</b>				2. DATE OF DEATH MONTH DAY YEAR <b>03 02 94</b>		3. TIME OF DEATH HOURS MINUTES <b>4:00 A.</b>	
4. SOCIAL SECURITY NUMBER <b>213-01-2105</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>79</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>05-27-14</b>	8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>13 MAPLE AVENUE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CATONSVILLE</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>CATONSVILLE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>13 MAPLE AVENUE</b>				10f. ZIP CODE <b>21228</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>HENRY A. HARRIS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>RUBY WYCHE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>BARBARA McCLANAHAN (DAUGHTER)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13 MAPLE AVENUE CATONSVILLE, MARYLAND 21228</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>DRUID RIDGE CEMETERY 03/04/94</b>		20c. LOCATION — City or Town, State <b>PIKESVILLE MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Russell Witzke</i>				22. NAME AND ADDRESS OF FACILITY <b>LEROY M &amp; RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pancreatic carcinoma</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>6 Mon.</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Damian E. Birchess MD</i>				29c. LICENSE NUMBER <b>022114</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 4, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAMIAN E. BIRCHES, MD 5411 Old Frederick Rd. 21229</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 08 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			



94-0961-033

B.K.S

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06920

1. DECEDENT'S NAME (First, Middle, Last) THAPPANIKHA KHUOCH ANG				2. DATE OF DEATH MONTH DAY YEAR FEB. 26 94		3. TIME OF DEATH 8:00 A M	
4. SOCIAL SECURITY NUMBER 586-34-2775		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 24 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 4, 1969	
9a. FACILITY NAME (If not institution, give street and number) 3207 NAYLOR ROAD				9b. CITY, TOWN OR LOCATION OF DEATH HILLCREST HEIGHTS		9c. COUNTY OF DEATH PRINCE GEORGES	
RESIDENCE OF DECEDENT							
10a. STATE Virginia		10b. COUNTY Fairfax		10c. CITY, TOWN OR LOCATION Falls Church		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6901 Chestnut Ave.				10f. ZIP CODE 22042		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Asian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Baker		16b. KIND OF BUSINESS/INDUSTRY Self Employed			
17. FATHER'S NAME (First, Middle, Last) Norecar Ang				18. MOTHER'S NAME (First, Middle, Maiden Surname) Suvaly Ngin			
19a. INFORMANT'S NAME (Type/Print) Norecar Ang				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6901 Chestnut Ave., Falls Church, Va. 22042			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Northern Va. Crematory 3/5/94		20c. LOCATION — City or Town, State Arlington, Va.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald J. Hager</i>				22. NAME AND ADDRESS OF FACILITY Arlington Funeral Home 3901 N. Fairfax Dr., Arl., Va. 22203			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE GUNSHOT WOUNDS DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year) FEB. 26, 1994		26b. TIME OF INJURY M		26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		26d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) ROADWAY		26e. DESCRIBE HOW INJURY OCCURRED SUBJECT SHOT			
		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3207 NAYLOR ROAD, HILLCREST, MD.					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thampanika Khouch</i>				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) FEB. 27, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARYDOWNS A-KOROU 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAR 08 1994				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94-0936-510

blh

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06921

1. DECEDENT'S NAME (First, Middle, Last) Richard W. Apgar				2. DATE OF DEATH MONTH DAY YEAR Feb 24 1994		3. TIME OF DEATH 1559 M	
4. SOCIAL SECURITY NUMBER 136-34-9104		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 49 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 29, 1944	
8. BIRTHPLACE (State or Foreign Country) Plainfield, NJ				9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH Baltimore				10a. STATE PA		10b. COUNTY York	
10c. CITY, TOWN OR LOCATION Glen Rock				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 253 Hanover Street	
10f. ZIP CODE 17327				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Realtor		16b. KIND OF BUSINESS/INDUSTRY Sales/Real Estate	
17. FATHER'S NAME (First, Middle, Last) John C. Apgar Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Theodosia Wellborn			
19a. INFORMANT'S NAME (Type/Print) Cassandra H. Apgar				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 253 Hanover St. Glen Rock, PA 17327			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fairmont Rural Cemetery		20c. LOCATION — City or Town, State Califon, NJ	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Geiple Funeral Home, Inc. 53 Main St. Glen Rock, PA 17327			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiomyopathy</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Insulin Dependent Diabetes Mellitus</u> <u>Hypertension</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Dennis J. Chute M.D.</u>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) Feb 25 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAR 08 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

94 06922

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Cecelia Virginia ANDREWS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 20 1994</b>		3. TIME OF DEATH M <b>2347</b>	
4. SOCIAL SECURITY NUMBER <b>219-12-1279</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 8, 1918</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Washington County Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>		9c. COUNTY OF DEATH <b>Washington</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Williamsport</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>251 Otho Holland Drive</b>				10f. ZIP CODE <b>21795</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>her own home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Edward Showe</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bertha J. Sweitzer</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mark W. Andrews</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16816 Hampton Road, Williamsport, Maryland 21795</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rose Hill Cemetery 2-23-94</b>		20c. LOCATION — City or Town, State <b>Hagerstown, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott Minnich</i>				22. NAME AND ADDRESS OF FACILITY <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. Renal Failure</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>d.</b>							Approximate Interval Between Onset and Death <b>1 year</b> <b>2 days</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Carcinoma of Breast -</b> <b>Liver carcinoma</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. [Signature]</i>				29c. LICENSE NUMBER <b>D21457</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/22/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ABDUL WAHED, MD-12821 OAK HILL AVE. HAGERSTOWN MD</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2

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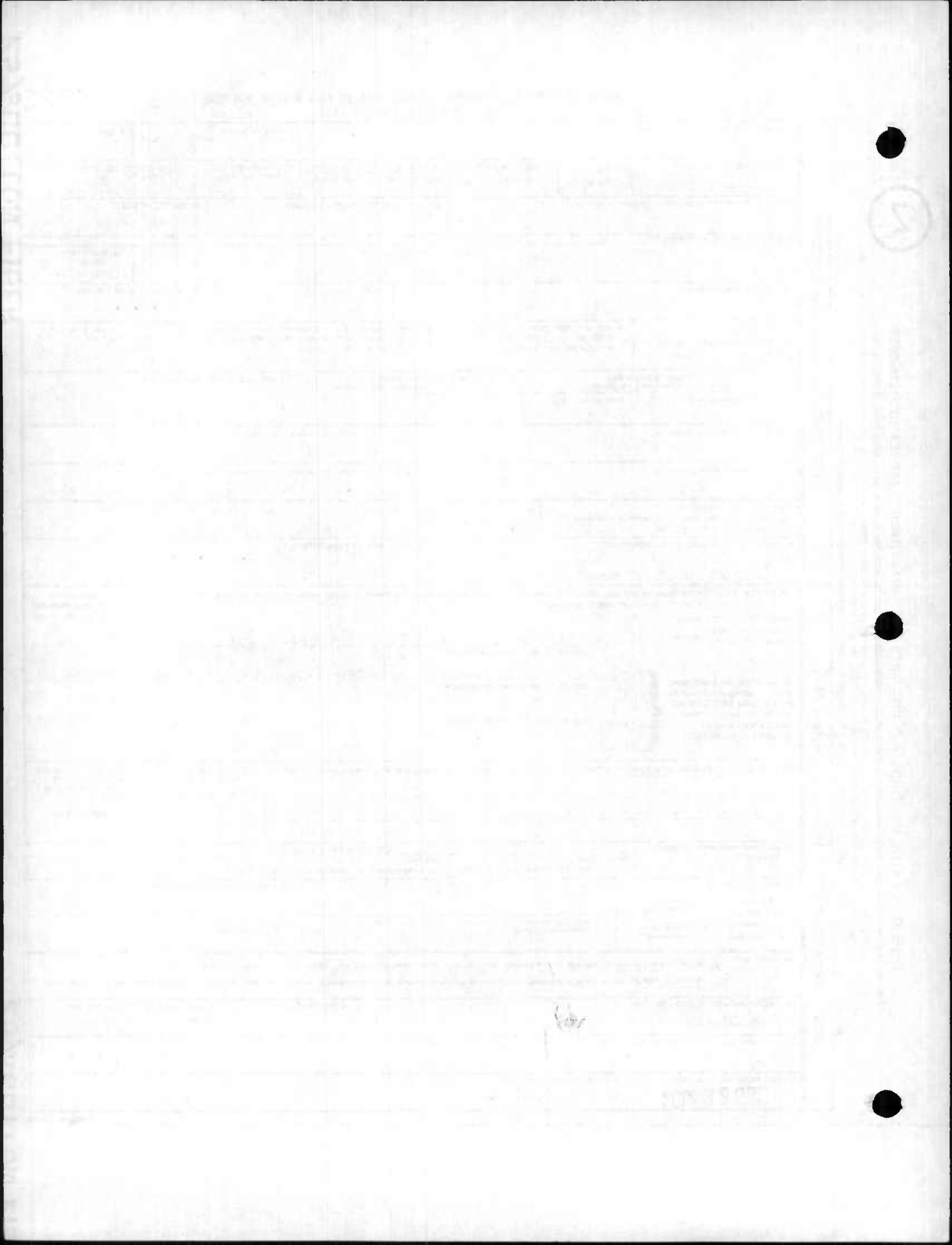


1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06923

1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH CATHERINE BRANDENBURG			2. DATE OF DEATH MONTH DAY YEAR 02/23/94		3. TIME OF DEATH 8:20 AM
4. SOCIAL SECURITY NUMBER 215-18-1761	5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	7. DATE OF BIRTH (Month, Day, Year) 03/06/1906		8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) Clear View Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington
RESIDENCE OF DECEDENT					
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1104 Potomac Avenue			
10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		16b. KIND OF BUSINESS/INDUSTRY Department Store			
17. FATHER'S NAME (First, Middle, Last) Emory Luther Bittle			18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha May Summers		
19a. INFORMANT'S NAME (Type/Print) Richard Bittle			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1104 Potomac Ave., Hagerstown, Maryland 21740		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Paul's Lutheran Cemetery		20c. LOCATION — City or Town, State 2/25/94 Myersville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patricia L. Ricketts</i>			22. NAME AND ADDRESS OF FACILITY 504 Main St., P. O. Box 136 Ricketts Funeral Home Myersville, MD 21773		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Sepsis due to Multiple deep decubiti</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia - Severe</i> <i>Urinary Infection - Severe</i>					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward W. Dittman</i>			29c. LICENSE NUMBER D0-1062		29d. DATE SIGNED (Month, Day, Year) 2/23/94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Edward W. Dittman MD 212 W. Washington St Hagerstown, MD 21740					
31. DATE FILED (Month, Day, Year) FEB 28 1994		32. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i>			



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06924

1. DECEDENT'S NAME (First, Middle, Last) Thomas Charles BLICKENSTAFF						2. DATE OF DEATH MONTH DAY YEAR Feb. 24 1994		3. TIME OF DEATH M		
4. SOCIAL SECURITY NUMBER 219-05-0633		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 10 1919		8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) 10918 Coffman Avenue						9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington		
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 10918 Coffman Avenue				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W. II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Realtor		16b. KIND OF BUSINESS/INDUSTRY Real Estate				
17. FATHER'S NAME (First, Middle, Last) Foster Blickenstaff						18. MOTHER'S NAME (First, Middle, Maiden Surname) Lutie Eckstine				
19a. INFORMANT'S NAME (Type/Print) Florence B. Blickenstaff				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10918 Coffman Avenue Hagerstown, Maryland 21740						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery 2-26-94		DATE 2-26-94		20c. LOCATION — City or Town, State Hagerstown, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott M. Minnick				22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrest DUE TO (OR AS A CONSEQUENCE OF): b. Metastatic carcinoma of prostate DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. PLACE OF DEATH (Check only one)				
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER George K. Howard MD Ph.D.		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 2/25/94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										
31. DATE FILED (Month, Day, Year) FEB 25 1994				32. REGISTRAR'S SIGNATURE John B. ...						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

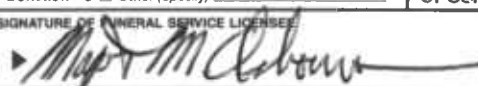
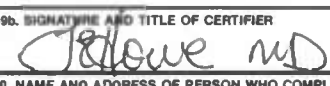



**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

94 06925

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>BESSIE VANZULIA BANZHOFF</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 21 1994</b>		3. TIME OF DEATH <b>8:10 P M</b>	
4. SOCIAL SECURITY NUMBER <b>220-28-3165</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>98</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 29, 1895</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Williamsport Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Williamsport</b>		9c. COUNTY OF DEATH <b>WASHINGTON</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Williamsport</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>122 W. Potomac St.</b>				10f. ZIP CODE <b>21795</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Calvin Liday</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Catherine Geesy</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Leo E. Riffle</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box # 127 Williamsport, MD 21795</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Greenlawn Memorial Park Feb. 25, 1994</b>		20c. LOCATION — City or Town, State <b>Williamsport, MD 21795</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>OSBORNE FUNERAL HOME P.O. Box # 348 Williamsport, MD 21795</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CACHEXIA</b> DUE TO (OR AS A CONSEQUENCE OF):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CONGESTIVE HEART FAILURE</b> <b>MULTI-INFARCT DEMENTIA</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Dr. Ted E. Howe MD</b>				29c. LICENSE NUMBER <b>D 33700</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEBRUARY 22, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Ted E. Howe, 18100 Marden Lane, Olney, MD 20832</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06926

1. DECEDENT'S NAME (First, Middle, Last) ROSELLA SMITH BAILEY				2. DATE OF DEATH MONTH DAY YEAR February 23 1994				3. TIME OF DEATH noon M			
4. SOCIAL SECURITY NUMBER 187-20-0084		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 5 1926		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) 6123 Twin Point Cove Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Cambridge				9c. COUNTY OF DEATH Dorchester			
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Cambridge				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 6123 Twin Point Cove Road				10f. ZIP CODE 21613		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMY FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) clerk		16b. KIND OF BUSINESS/INDUSTRY U.S. government					
17. FATHER'S NAME (First, Middle, Last) Frank Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hattie Clark							
19a. INFORMANT'S NAME (Type/Print) Claude J. Bailey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6123 Twin Point Cove Rd. Cambridge Md. 21613							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory Feb. 24th Salisbury Maryland		DATE		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kenneth R. Thomas				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge Md. 21613							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): b. Chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF): c. Emphysema DUE TO (OR AS A CONSEQUENCE OF): d. Cigarette smoking Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 2 months 3 yrs 5 yrs 30 yrs			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Rosemary M. Harris MD				29c. LICENSE NUMBER D-43707		29d. DATE SIGNED (Month, Day, Year) 2/24/94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Rosemary Harris, M.D. 408 Byrn St. Cambridge Md. 21613											
31. DATE FILED (Month, Day, Year) FEB 25 '94				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

Cambridge, +



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06927

1. DECEDENT'S NAME (First, Middle, Last) <b>Frieda HENRIETTA BEVARD</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>19</b> YEAR <b>94</b>		3. TIME OF DEATH <b>11:50 P.M.</b>					
4. SOCIAL SECURITY NUMBER <b>212-05-2542</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>94</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6/23/1899</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Bel Air Convalescent Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Bel Air</b>			9c. COUNTY OF DEATH <b>Harford</b>				
RESIDENCE OF DECEDENT											
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Jarrettsville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>3830 Federal Hill Road</b>				10f. ZIP CODE <b>21084</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>--</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Julius Carl Winskowski</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Wanda Frances Schultz</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Joyce M. Peak</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3927 Federal Hill Rd. Jarrettsville, Md. 21084</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Bel Air Mem. Gardens 2/23</b>		20c. LOCATION — City or Town, State <b>Bel Air, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>M. Gladstone Kurtz</i>				22. NAME AND ADDRESS OF FACILITY <b>Kurtz Funeral Home Jarrettsville, Maryland</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cerebrovascular accident lwb</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Due to (OR AS A CONSEQUENCE OF):</b> <b>Congestive heart failure</b> b. <b>Due to (OR AS A CONSEQUENCE OF):</b> <b>Coronary artery disease</b> c. <b>Due to (OR AS A CONSEQUENCE OF):</b> d. <b>Due to (OR AS A CONSEQUENCE OF):</b>								Approximate interval Between Onset and Death <b>years</b> <b>year</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's dementia</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>P. Dubyalski MD</i>								29c. LICENSE NUMBER <b>D29227</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/22/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Patricia A Dubyalski</b>											
31. DATE FILED (Month, Day, Year) <b>FEB 25 '94</b>				32. REGISTRAR'S SIGNATURE <i>G. Davidson-Randall</i>							



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94 06928

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ILSE ALARCON BAILEY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB. 19, 1994</b>		3. TIME OF DEATH <b>6:03 AM</b>	
4. SOCIAL SECURITY NUMBER —		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>58</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>June 26, 1935</b>	8. BIRTHPLACE (State or Foreign Country) <b>Bolivia</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>3500 Shephard Street</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Chevy Chase</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Chevy Chase</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3500 Shephard Street</b>				10f. ZIP CODE <b>20815</b>		10g. CITIZEN OF WHAT COUNTRY? <b>Bolivia</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Home Maker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Rafael Alarcon</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bertha Abecia</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William Bailey</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3500 Shephard Street Bethesda, Maryland 20815</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mount Comfort Crematory</b>		DATE <b>2/22</b>		20c. LOCATION — City or Town, State <b>Alexandria, VA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leonor Jimenez</i>				22. NAME AND ADDRESS OF FACILITY <b>Joseph Gawler's Sons, Inc. 20815 5130 Wisconsin Avenue, NW Washington, DC</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary arrest</b>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <b>adeno carcinoma of peritoneum</b>							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Susan Otero, MD</i>				29c. LICENSE NUMBER <b>14270</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB. 19, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SUSAN OTERO M.D. 1145 19th STREET N.W. #717 WASHINGTON, D.C. 20036</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06929

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>HERBERT BLUMENTHAL</b>				2. DATE OF DEATH MONTH <b>FEBRUARY</b> DAY <b>19</b> YEAR <b>1994</b>				3. TIME OF DEATH <b>5:45 P. M.</b>			
4. SOCIAL SECURITY NUMBER <b>577-10-1949</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>83</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>		7. DATE OF BIRTH (Month, Day, Year) <b>FEB. 18, 1911</b>		8. BIRTHPLACE (State or Foreign Country) <b>NEW YORK</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>				9c. COUNTY OF DEATH <b>MONTGOMERY</b>			
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3526 PEARTREE COURT, #21</b>				10f. ZIP CODE <b>20906</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>RETAILER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>BLOOMINGDALE'S</b>			
17. FATHER'S NAME (First, Middle, Last) <b>OSCAR BLUMENTHAL</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ROSE MANN</b>							
19a. INFORMANT'S NAME (Type/Print) <b>GERALD BLUMENTHAL (SON)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5607 ROOSEVELT STREET, BETHESDA, MD 20817</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>JUDEAN MEMORIAL GARDENS 2/21</b>				20c. LOCATION — City or Town, State <b>OLNEY, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> a. <b>myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>coronary atherosclerosis</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>arteriosclerosis</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>hypertension</b> Approximate Interval Between Onset and Death <b>3 yrs</b>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>2/20/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>STANLEY A. SCHWARTZ, M.D., 5454 WISCONSIN AVENUE, #1345 CHEVY CHASE, MD 20815</b>											
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>				32. REGISTRAR'S SIGNATURE 							

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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06930

1. DECEDENT'S NAME (First, Middle, Last) <b>FRANCIS X. BROWN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 18 1994</b>		3. TIME OF DEATH <b>3:46 PM</b>	
4. SOCIAL SECURITY NUMBER <b>579-24-8436</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 18, 1925 Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ROCKVILLE</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>58 Orchard Way North</b>				10f. ZIP CODE <b>20854</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Administrator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>American Institute of Architects</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Walter A. Brown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edith A. Bryan</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Anna M. Brown</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>58 Orchard Way North, Rockville, Maryland 20854</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Quantico National Cemetery</b>		20c. LOCATION — City or Town, State <b>Triangle, Virginia</b>		20d. DATE <b>2/22/94</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert A. Pumphrey</b>		M00198		22. NAME AND ADDRESS OF FACILITY <b>Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>VENTRICULAR FIBRILLATION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>HYPERTENSION</b> DUE TO (OR AS A CONSEQUENCE OF): <b>MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF): <b>METASTATIC CARCINOMA</b>						Approximate Interval Between Onset and Death <b>45 min</b> <b>24 hrs</b> <b>48 hrs</b> <b>14 months</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHEMOBRADYLATION OF TUMOR</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		27. DATE OF INJURY (Month, Day, Year)		28. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>		29c. LICENSE NUMBER <b>Am 2600597</b>		29d. DATE SIGNED (Month, Day, Year) <b>February 18, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Mark Melton MD 640 Rockledge Dr. Bethesda MD 20817</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06931

1. DECEDENT'S NAME (First, Middle, Last) <b>FREDERICK G. BOHME</b>				2. DATE OF DEATH MONTH <b>FEBRUARY</b> DAY <b>12</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>3:30 P M</b>					
4. SOCIAL SECURITY NUMBER <b>527-05-0512</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>DEC. 2, 1921</b>		8. BIRTHPLACE (State or Foreign Country) <b>New York</b>			
9a. FACILITY NAME (If not Institution, give street and number) <b>9111 Sudbury Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>			9c. COUNTY OF DEATH <b>Montgomery</b>				
RESIDENCE OF DECEDENT				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>9111 Sudbury Road</b>		10f. ZIP CODE <b>20901</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>5+</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chief Historian</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Census Bureau</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Fred G. Bohme</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen C. Solms</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Jackson H. Morton</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9504 Ocala Street Silver Spring, Maryland 20901</b>							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		DATE <b>2/13</b>		20c. LOCATION — City or Town, State <b>Alexandria, Virginia</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Timothy J. Campbell</i>				22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home</b> <b>500 University Blvd. W. Silver Spring, MD.</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Atherosclerotic Heart Disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		28. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY <b>M</b>		26c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURRED			
26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Tauter</i>				29c. LICENSE NUMBER <b>D08546</b>		29d. DATE SIGNED (Month, Day, Year) <b>Feb 13 94</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John Tauter 8218 Wisconsin ave Bethesda</b>											
31. DATE FILED (Month, Day, Year) <b>FEB 14 1994</b>				32. REGISTRAR'S SIGNATURE <i>John Tauter</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3, 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



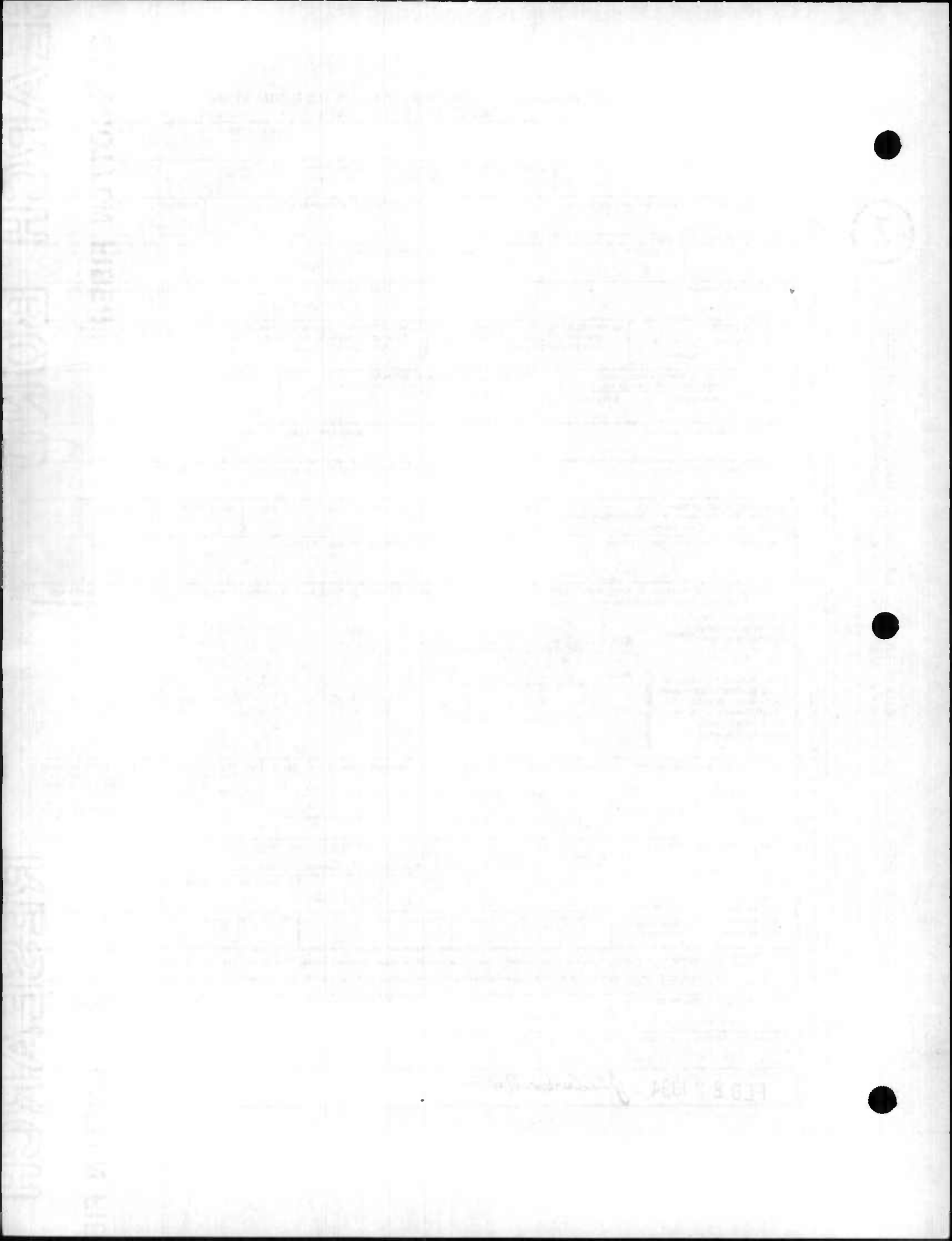
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO. 94 06932			
1. DECEDENT'S NAME (First, Middle, Last) Cecil R. Bell				2. DATE OF DEATH MONTH DAY YEAR February 14, 1994				3. TIME OF DEATH 6:20 p.m.							
4. SOCIAL SECURITY NUMBER 127-12-4782		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) May 13, 1903		8. BIRTHPLACE (State or Foreign Country) Ireland			
9a. FACILITY NAME (If not institution, give street and number) 19120 Muncaster Road				9b. CITY, TOWN OR LOCATION OF DEATH Derwood				9c. COUNTY OF DEATH Montgomery							
RESIDENCE OF DECEDENT				10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Derwood		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 19120 Muncaster Road				10f. ZIP CODE 20855				10g. CITIZEN OF WHAT COUNTRY? United States							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1943-1945		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 0		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Iron Worker		15b. KIND OF BUSINESS/INDUSTRY Atlas Iron Company											
17. FATHER'S NAME (First, Middle, Last) Samuel G. Bell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Unobtainable											
19a. INFORMANT'S NAME (Type/Print) Betty Cleveland				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2322 Pinneberg Ave. Rockville, Maryland 20851											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Fort Lincoln Cemetery 2-18-94		DATE 2-18-94		20c. LOCATION — City or Town, State Brentwood, Maryland									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Cal S. K...</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, Maryland											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardio Pulmonary Arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>1. Neoplasm</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>metastatic cancer 10 unspecified 6 months</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval Between Onset and Death 1 week							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia</i> <i>Styrene</i> <i>Polyneuropathy</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURRED							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Shirley J. (unclassified)</i>				29c. LICENSE NUMBER 025410		29d. DATE SIGNED (Month, Day, Year) 2/17/94							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3801 International Drive Silver Spring MD 20912															
31. DATE FILED (Month, Day, Year) FEB 22 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>											



94-774-031

ASP

ITEMS: 23 PART I, 27, PER MEO FILM G-709 3/17/94 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06933

1. DECEDENT'S NAME (First, Middle, Last) <b>CARL F. BUSHONG</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB 14 1994</b>		3. TIME OF DEATH 8:08 P M	
4. SOCIAL SECURITY NUMBER <b>218-90-0459</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>33</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 15, 1960</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. FACILITY NAME (If not institution, give street and number) <b>5321 NORBECK RD</b>			
10. CITY, TOWN OR LOCATION OF DEATH <b>ROCKVILLE</b>				11. COUNTY OF DEATH <b>MONTGOMERY</b>			
12. RESIDENCE OF DECEDENT 10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5321 Norbeck Road</b>				10f. ZIP CODE <b>20853</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Auto Mechanic</b>		16. KIND OF BUSINESS/INDUSTRY <b>Auto Dealer</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Edgar W. Bushong</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marjorie Whittaker</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Marjorie W. Bushong</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1231 Freil Road, N.E., Palm Bay, Florida 32905</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>February 28, 1994</b> <b>Fountainhead Memorial Park</b>		20c. LOCATION — City or Town, State <b>Palm Bay, Florida</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert A. Pumphrey</b> M00198				22. NAME AND ADDRESS OF FACILITY <b>Robert A. Pumphrey Funeral Home/Rockville, Inc.</b> <b>300 West Montgomery Avenue</b> <b>Rockville, Maryland 20850-2805</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>MYOCARDIAL HYPERTROPHY AND PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29a. SIGNATURE AND TITLE OF CERTIFIER <b>Mark F. Gove, Jr. MD</b>				29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB 15, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 Penn St Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06934

1. DECEDENT'S NAME (First, Middle, Last) PEARL COMPTON BOESMAN				2. DATE OF DEATH FEBRUARY 20, 1994				3. TIME OF DEATH 6:00p.m.									
4. SOCIAL SECURITY NUMBER 191-28-4998				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Jan. 11, 1906		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL								9b. CITY, TOWN OR LOCATION OF DEATH LANHAM-SEABROOK				9c. COUNTY OF DEATH PRINCE GEORGE'S CO.					
RESIDENCE OF DECEDENT																	
10a. STATE none				10b. COUNTY none				10c. CITY, TOWN OR LOCATION Washington, D.C.				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER 2822 Kanawha Street, N.W.								10f. ZIP CODE 20015				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) housewife				16b. KIND OF BUSINESS/INDUSTRY own home									
17. FATHER'S NAME (First, Middle, Last) Edward Clarence Compton								18. MOTHER'S NAME (First, Middle, Maiden Surname) Stella May Dixon									
19a. INFORMANT'S NAME (Type/Print) William C. Boesman								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2822 Kanawha St., N.W., Washington, D.C. 20015									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Blairsville Cemetery Co. 2-15-94				DATE				20c. LOCATION — City or Town, State Blairsville, Pa.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. DeVol</i>								22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 2222 Wisconsin Ave., N.W., Wash., DC 20007									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Pneumonitis</i>																	
Due to (or as a consequence of):																	
b. <i>Dehydration</i>																	
Due to (or as a consequence of):																	
c. <i>Anemia Hypoxemia</i>																	
Due to (or as a consequence of):																	
d. <i>Congestive heart Failure</i>																	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Anemia Hypoxemia</i> <i>Congestive heart Failure</i>																	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rakesh Arora, M.D.</i>								29c. LICENSE NUMBER <i>D20108</i>				29d. DATE SIGNED (Month, Day, Year) <i>2/21/94</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Rakesh Arora 14300 Gallant Fox La Suite 222 Bowie, MD 20715</i>																	
31. DATE FILED (Month, Day, Year) <i>FEB 23 1994</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>													

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06935

1. DECEDENT'S NAME (First, Middle, Last) <b>MORRIS BEST</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 21, 1994</b>		3. TIME OF DEATH <b>11:25 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>579-18-7805</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 15, 1923</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>12906 ESTELLE ROAD</b>				10f. ZIP CODE <b>20906</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TAXI DRIVER</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>VERNON BEST</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HESTER EARPE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CLARA N. BEST</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12906 ESTELLE ROAD SILVER SPRING, MARYLAND 20906</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GATE OF HEAVEN CEMETERY 2/24</b>		20c. LOCATION — City or Town, State <b>SILVER SPRING, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>David H. Stahl</b>				22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Dilated Cardiomyopathy</b> DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Mitral Regurgitation Ventricular Tachycardia</b>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>John M. Churnia, MD</b>				29c. LICENSE NUMBER <b>D25080</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/21/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>10313 Georgia Ave, Silver Spring, MD</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 through 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7

10-1-12 Dec 1912

10-1-12 Dec 1912

X

X

10-1-12 Dec 1912

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06936

1. DECEDENT'S NAME (First, Middle, Last) <i>Louise Bradford</i>				2. DATE OF DEATH MONTH DAY YEAR <i>Feb. 18 94</i>				3. TIME OF DEATH <i>8:55 A.M.</i>			
4. SOCIAL SECURITY NUMBER <i>216-46-9378</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>81</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>June 18, 1912</i>		8. BIRTHPLACE (State or Foreign Country) <i>Washington, D.C.</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Suburban Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Bethesda</i>				9c. COUNTY OF DEATH <i>Montgomery</i>			
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Bethesda</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <i>7514 Radnor Road</i>				10f. ZIP CODE <i>20817</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Teacher</i>		16b. KIND OF BUSINESS/INDUSTRY <i>D.C. Public Schools</i>							
17. FATHER'S NAME (First, Middle, Last) <i>Samuel Frederick Hildebrand</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Claudia Chaillaux</i>							
19a. INFORMANT'S NAME (Type/Print) <i>Ann B. Sullivan</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>12720 Atherton Drive Silver Spring, MD 20906</i>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Fort Lincoln Cemetery</i>		DATE <i>2/22</i>		20c. LOCATION — City or Town, State <i>Brentwood, Maryland</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Vernon Simmons</i>				22. NAME AND ADDRESS OF FACILITY <i>Joseph Gawler's Sons, Inc. 5130 WI Ave., NW Washington, D.C. 20016</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Multiple Pulmonary Embol.</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. Fractured Rt. Hip</i>  <i>c.</i>  <i>d.</i>								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <i>Jan 29 94</i>		28b. TIME OF INJURY <i>9:00 M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <i>Fell on ice</i>			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>Home, outside</i>				28f. LOCATION (Street and Number, City or Town, State) <i>7514 Radnor Rd.</i>					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John J. Conley</i>						29c. LICENSE NUMBER <i>208541</i>		29d. DATE SIGNED (Month, Day, Year) <i>Feb 18-94</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John Conley 8218 Wisconsin Ave Bethesda</i>											
31. DATE FILED (Month, Day, Year) <i>FEB 23 1994</i>											
32. REGISTRAR'S SIGNATURE <i>John J. Conley</i>											



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06937

1. DECEDENT'S NAME (First, Middle, Last) KAY K. BRILL AKA KENNA JEAN BRILL				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 22, 1994		3. TIME OF DEATH 12:59 P. M.					
4. SOCIAL SECURITY NUMBER 358-30-4901		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN. 21, 1940		8. BIRTHPLACE (State or Foreign Country) ILLINOIS			
9a. FACILITY NAME (If not institution, give street and number) HOLY CROSS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING			9c. COUNTY OF DEATH MONTGOMERY				
10a. STATE MARYLAND				10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION SILVER SPRING		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 9040 PINEY BRANCH ROAD, #101				10f. ZIP CODE 20903		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) RALPH ARBOGAST				18. MOTHER'S NAME (First, Middle, Maiden Surname) CHARLOTTE JEAN DOTY							
19a. INFORMANT'S NAME (Type/Print) CARL F. BRILL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9040 PINEY BRANCH ROAD, #101, SILVER SPRING, MD 20903							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY 2/24		20c. LOCATION — City or Town, State ALEXANDRIA, VA							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven D. Stord</i>				22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20903							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Renal Failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Anastomotic leak</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death ~1 1/2 mon ~1 1/2 mon ~4 1/2 mon			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Horbid Obesity</i> <i>Diabetes</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Frank Lin</i>				29c. LICENSE NUMBER D43199		29d. DATE SIGNED (Month, Day, Year) 2/22/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Frank Lin</i> 10301 Georgia Ave. St 205, Sil Spr MD 20902											
31. DATE FILED (Month, Day, Year) FEB 25 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

REC'D 1934

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06938

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES A. CARR</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>19</b> YEAR <b>94</b>		3. TIME OF DEATH <b>2:30 P M</b>			
4. SOCIAL SECURITY NUMBER <b>084-18-7469</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>96</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 8 1897</b>		8. BIRTHPLACE (State or Foreign Country) <b>New York</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>506 Heavittree Garth</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Severna Park</b>				9c. COUNTY OF DEATH <b>Anne Arundle</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundle</b>		10c. CITY, TOWN OR LOCATION <b>Severna Park</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>506 Heavittree Garth</b>				10f. ZIP CODE <b>21146</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>5</b> College (1-4 or 5+) <b>0</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>			15b. KIND OF BUSINESS/INDUSTRY <b>Hospital</b>				
17. FATHER'S NAME (First, Middle, Last) <b>George E. Carr</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Minnie Fuller</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Robert Carr</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>506 Heavittree Garth Severna Park, Maryland 21146</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Greenlawn Memorial Park 2-22-94</b>		20c. LOCATION — City or Town, State <b>Williamsport, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott Minnich</i>				22. NAME AND ADDRESS OF FACILITY <b>Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>dehydration and electrolyte imbalance</b>  Sequently list condition, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <b>vomiting</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>gastric atony</b> c. DUE TO (OR AS A CONSEQUENCE OF): <b>old age</b> d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>induration</b>								Approximate Interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James J. Benjamin, M.D.</i>				29c. LICENSE NUMBER <b>D8357</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/19/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JAMES J. BENJAMIN, M.D. - 653 Old Mill Road, Millersville, Md. 21108</b>									
31. DATE FILED (Month, Day, Year) <b>FEB 25 1994</b>				32. REGISTRAR'S SIGNATURE <i>John S. ...</i>					





1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06939

1. DECEDENT'S NAME (First, Middle, Last) <i>Ken Chuan Chou</i>				2. DATE OF DEATH MONTH <i>02</i> DAY <i>15</i> YEAR <i>1994</i>		3. TIME OF DEATH <i>2:24 P</i>	
4. SOCIAL SECURITY NUMBER <i>446-64-7386</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>75</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>	7. DATE OF BIRTH (Month, Day, Year) <i>Aug. 16, 1918</i>	
8. FACILITY NAME (If not institution, give street and number) <i>Shady Grove Adventist Hosp.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Rockville</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Potomac</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>11121 Smokey Quartz Lane</i>				10f. ZIP CODE <i>20854</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Asian</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 8+) <i>4</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Professor</i>		15b. KIND OF BUSINESS/INDUSTRY <i>Education</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Shang - Wen Chou</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Shih Wang</i>			
19a. INFORMANT'S NAME (Type/Print) <i>J.J. Chou</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>same as #10</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Metropolitan Crematory</i>		DATE <i>2/20</i>		20c. LOCATION — City or Town, State <i>Alexandria, Virginia</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>De Vol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. ASPIRATION PNEUMONIA</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>P. Talwar, M.D.</i>		29c. LICENSE NUMBER <i>D 36552</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/16/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>P. Talwar, 50-W EDMONSTON DRIVE, ROCKVILLE MD. 20852</i>							
31. DATE FILED (Month, Day, Year) <i>FEB 22 1994</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATIONER

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94 06940

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Armand A. Capozzi				2. DATE OF DEATH MONTH DAY YEAR February 18, 1994		3. TIME OF DEATH 8:30 pm M	
4. SOCIAL SECURITY NUMBER 118-03-6405		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 4, 1917	
9a. FACILITY NAME (If not institution, give street and number) 199 Rollins Avenue #406				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 199 Rollins Avenue #406				10f. ZIP CODE 20852		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic		16b. KIND OF BUSINESS/INDUSTRY Department of Defense			
17. FATHER'S NAME (First, Middle, Last) Anthony Capozzi				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nancy Venturino			
19a. INFORMANT'S NAME (Type/Print) Elizabeth Capozzi				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 199 Rollins Avenue #406, Rockville, MD 20852			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) February 22, 1994 Montgomery Crematorium Inc.		20c. LOCATION — City or Town, State Bethesda, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Serge T. Joseph M00335				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805			
23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF):  b. Metastatic Carcinoma of Lung DUE TO (OR AS A CONSEQUENCE OF):  c. _____ DUE TO (OR AS A CONSEQUENCE OF):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Lung Disease							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Elliot R. Goldstein MD				29c. LICENSE NUMBER D03518		29d. DATE SIGNED (Month, Day, Year) 2/22/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Elliot R. Goldstein, 9410 Old Georgetown Road, Bethesda, Maryland 20814							
31. DATE FILED (Month, Day, Year) FEB 22 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06941

1. DECEDENT'S NAME (First, Middle, Last) <b>CHENG KEIN CHAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb 19 94</b>		3. TIME OF DEATH <b>11:07A M</b>	
4. SOCIAL SECURITY NUMBER <b>213-90-8310</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>APRIL 11, 1913</b>	
8. BIRTHPLACE (State or Foreign Country) <b>CHINA</b>				9a. FACILITY NAME (If not Institution, give street and number) <b>WASHINGTON ADVENTIST HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>TAKOMA PARK</b>	
9c. COUNTY OF DEATH <b>MONTGOMERY</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>	
10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>2704 BEECHMONT LANE</b>	
10f. ZIP CODE <b>20906</b>				10g. CITIZEN OF WHAT COUNTRY? <b>CHINA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE/ASIAN</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>ELEMENTARY</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>UNKNOWN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>UNKNOWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LAI KUEN OUACH</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2704 BEECHMONT LANE SILVER SPRING, MARYLAND 20906</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>METROPOLITAN CREMATORY</b>		20c. LOCATION — City or Town, State <b>ALEXANDRIA, VIRGINIA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harold S. Branson Sr.</i>				22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Subdural hematoma</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>2-9-94</b>		28b. TIME OF INJURY <b>10 P M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED <b>Fell on Pothole</b>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>2704 Beechmont Lane</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Tauber</i>				29c. LICENSE NUMBER <b>202546</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-20-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John Tauber 8218 Wisconsin Ave Bethesda MD</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 6 and 7 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06942

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) YU TA CHANG				2. DATE OF DEATH MONTH DAY YEAR FEB 14 1994		3. TIME OF DEATH 8:28 A M				
4. SOCIAL SECURITY NUMBER 215-38-8919		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG 17, 1911		8. BIRTHPLACE (State or Foreign Country) CHINA		
9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA			9c. COUNTY OF DEATH MONTGOMERY			
10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGE'S		10c. CITY, TOWN OR LOCATION COLLEGE PARK			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 5020 MINEOLA ROAD				10f. ZIP CODE 20740		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1935 - 1965		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: ASIAN				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) U.S. NAVY			16b. KIND OF BUSINESS/INDUSTRY DEFENSE					
17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN						
19a. INFORMANT'S NAME (Type/Print) YIN F. CHANG				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5020 MINEOLA ROAD, COLLEGE PARK, MD 20740						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington Nat'l Cemetery		DATE 2/25		20c. LOCATION — City or Town, State Arlington, Va.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas S. Chambers #670				22. NAME AND ADDRESS OF FACILITY W.W. Chambers Co. Inc. 5801 Cleveland Ave. Riverdale, Md. 20737						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER E.M. Supinski MD				29c. LICENSE NUMBER MD-050978L (PA)			29d. DATE SIGNED (Month, Day, Year) 16 Feb 94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) E. M. SUPINSKI, LT, MC, USNR				NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600						
31. DATE FILED (Month, Day, Year) FEB 22 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Ross						



REVENUE BOARD

EXHIBIT

(4)

REVENUE BOARD

EXHIBIT



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06943

1. DECEDENT'S NAME (First, Middle, Last) <b>MARJORIE COHN</b>				2. DATE OF DEATH MONTH <b>FEBRUARY</b> DAY <b>24</b> , YEAR <b>1994</b>		3. TIME OF DEATH <b>10:17 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>149-14-2374</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>72</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	7. DATE OF BIRTH (Month, Day, Year) <b>JULY 10, 1921</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>ROCKVILLE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>13628 GRENOBLE DRIVE</b>				10f. ZIP CODE <b>20853</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>SAMUEL MITTLEMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNE ROST</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JULIUS COHN (HUSBAND)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13628 GRENOBLE DR., ROCKVILLE, MD 20853</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING DAVID MEMORIAL GARDEN 2/25</b>		DATE <b>2/25</b>		20c. LOCATION — City or Town, State <b>FALLS CHURCH, VA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Frank A. Stree</i>				22. NAME AND ADDRESS OF FACILITY <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE — ROCKVILLE, MD. 20852</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Leg cellulitis</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Stroke</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Myasthenia Gravis</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b> <b>Respiratory Failure</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Gauging Thaler MD</b>				29c. LICENSE NUMBER <b>D43430</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/24/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>11301 Rockville Pike N. Bettsdale MD</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 25 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06944

1. DECEDENT'S NAME (First, Middle, Last) <b>ROSE MARY DeLOUNNEY</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>21</b> YEAR <b>94</b>		3. TIME OF DEATH <b>746 AM</b>					
4. SOCIAL SECURITY NUMBER <b>21709 9825</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10 03 19</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>UMMS</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>			9c. COUNTY OF DEATH <b>Baltimore</b>				
RESIDENCE OF DECEDENT											
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Clear Spring</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER <b>13805 National Pike</b>				10f. ZIP CODE <b>21722</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>0</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>homemaker</b>			15b. KIND OF BUSINESS/INDUSTRY <b>her own home</b>						
17. FATHER'S NAME (First, Middle, Last) <b>John Luther Reedy</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Edith Martin</b>							
19a. INFORMANT'S NAME (Type/Print) <b>John W. DeLounney</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13805 National Pike, Clear Spring, Md. 21722</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Lawn Memorial Park</b>		DATE <b>2-25</b>		20c. LOCATION — City or Town, State <b>Hagerstown, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Scott Minnick</b>				22. NAME AND ADDRESS OF FACILITY <b>MINNICH FUNERAL HOME</b> <b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARDIORESPIRATORY ARREST</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>2</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>								29c. LICENSE NUMBER <b>MD D4636</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/21/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>22 J. GREENE ST BALTIMORE MD 21201</b>											
31. DATE FILED (Month, Day, Year) <b>02 FEB 23 1994</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06945

1. DECEDENT'S NAME (First, Middle, Last) Ann L. DePrey				2. DATE OF DEATH FEB. 20, 1994 YEAR				3. TIME OF DEATH 8:30 AM			
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Feb. 28, 1915		8. BIRTHPLACE (State or Foreign Country) Virginia	
9a. FACILITY NAME (If not institution, give street and number) Springbrook Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery			
10a. STATE MD				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 12325 New Hampshire Avenue				10f. ZIP CODE 20904				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Practical Nurse				16b. KIND OF BUSINESS/INDUSTRY Medicine			
17. FATHER'S NAME (First, Middle, Last) Randolph Franklin LaRue				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Camper							
19a. INFORMANT'S NAME (Type/Print) Amelia Freeman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 Oakland Hills Drive, Arnold, MD							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Crematory 2/22/94 DATE				20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Soni Short Holland</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring MD							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Chronic Obstructive Lung Disease</i> b. c. d. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark Eig</i>				29c. LICENSE NUMBER D24886		29d. DATE SIGNED (Month, Day, Year) 2/21/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Mark Eig				9801 Georgia Ave Silver Spring MD							
31. DATE FILED (Month, Day, Year) FEB 22 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>							



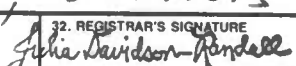


1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06946

1. DECEDENT'S NAME (First, Middle, Last) <b>Robert Deal Robert Joseph Deal</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>20</b> YEAR <b>94</b>		3. TIME OF DEATH <b>2:04 A M</b>			
4. SOCIAL SECURITY NUMBER <b>099-07-3118</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 19, 1916</b>		8. BIRTHPLACE (State or Foreign Country) <b>Connecticut</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Suburban Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>			9c. COUNTY OF DEATH <b>Montgomery</b>		
RESIDENCE OF DECEDENT									
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Bethesda</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>6203 Melvern Drive</b>				10f. ZIP CODE <b>20817</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII 1941-1945</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>6</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Business Executive</b>			15b. KIND OF BUSINESS/INDUSTRY <b>Petroleum Industry</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Robert O. Deal</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Louise Duffy</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Liberta Mary Deal (Wife)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as #10</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Suburban Crematory</b>		DATE <b>2-21</b>		20c. LOCATION — City or Town, State <b>Silver Spring, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>MO0827</b>				22. NAME AND ADDRESS OF FACILITY <b>Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory failure</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Pneumonia (Respiratory)</b> b. <b>Due to (OR AS A CONSEQUENCE OF):</b> c. <b>Surgery for Ca of (R) Lung</b> d. <b>Due to (OR AS A CONSEQUENCE OF):</b>								Approximate Interval Between Onset and Death <b>acute</b> <b>1 week</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CAD (SPO - CABG) also</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>104930</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/20/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. S. S. A. I. A., 804 viers Mill Rd Roanoke MD 20851</b>									
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06947

1. DECEDENT'S NAME (First, Middle, Last) SHIRLEY JEAN DEVAUGHN				2. DATE OF DEATH FEB 20 1994		3. TIME OF DEATH 2:20 AM	
4. SOCIAL SECURITY NUMBER 215-44-5733		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 46 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-1-1947	
9a. FACILITY NAME (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS		9c. COUNTY OF DEATH ANNE ARUNDEL	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Dunkirk		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6311 Oaklyn Court				10f. ZIP CODE 20754		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Private Business			
17. FATHER'S NAME (First, Middle, Last) Homer Louis Reece				18. MOTHER'S NAME (First, Middle, Maiden Surname) Stella Mae Stout			
19a. INFORMANT'S NAME (Type/Print) Carrie Michele DeV Vaughn				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3416 Olive Branch Drive Silver Spring, Maryland			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 3/4/94		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald V. Borgwardt				22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Injuries DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) FEB 19, 1994		28b. TIME OF INJURY 11:35P		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED PASSENGER IN AUTO/TRUCK		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) ON ROAD		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) RT. 2 & HARWOOD ROAD	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Julia Davidson-Rendell MD				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) FEB 20, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. ARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) FEB 25 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Rendell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06948

1. DECEDENT'S NAME (First, Middle, Last) <b>JACK CLEMENS DAVIS</b>				2. DATE OF DEATH MONTH <b>FEB</b> DAY <b>17</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>2:47</b> P M	
4. SOCIAL SECURITY NUMBER <b>224-52-3201</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN 22 1909</b>	
8. BIRTHPLACE (State or Foreign Country) <b>INDIANA</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BETHESDA</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>VIRGINIA</b>		10b. COUNTY <b>FAIRFAX</b>		10c. CITY, TOWN OR LOCATION <b>MCLEAN</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1120 PINE HILL ROAD</b>				10f. ZIP CODE <b>22101</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1942 - 1971</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+) <b>IL S. NAVY</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DEFENSE</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>SAMUEL NEWSOM DAVIS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BERTHA BALDWIN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ANNE G. DAVIS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1120 PINE HILL ROAD, MCLEAN, VA 22101</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arlington National Cemetery</b>		DATE <b>2/25</b>		20c. LOCATION — City or Town, State <b>Arlington, Virginia</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Reiner Simmons</i>				22. NAME AND ADDRESS OF FACILITY <b>Joseph Gawler's Sons</b> <b>5130 Wisconsin Ave. N.W. Washington D.C. 20016</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. M. Hill MD</i>				29c. LICENSE NUMBER <b>18870 (DC)</b>		29d. DATE SIGNED (Month, Day, Year) <b>02/18/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. M. HILL, LT, MC, USNR</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600</b>			
31. DATE FILED (Month, Day, Year) <b>FEB 25 1994</b>				32. REGISTRAR'S SIGNATURE <i>J. M. Hill</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) Evelyn Jean Eberle								2. DATE OF DEATH MONTH DAY YEAR 2 - 21 - 94				3. TIME OF DEATH 4:20 A M							
4. SOCIAL SECURITY NUMBER 157-30-8798				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 12-23-1902		8. BIRTHPLACE (State or Foreign Country) New Jersey					
9a. FACILITY NAME (If not institution, give street and number) Reeders Memorial Home								9b. CITY, TOWN OR LOCATION OF DEATH Boonsboro				9c. COUNTY OF DEATH Washington							
10a. STATE Md.				10b. COUNTY Washington				10c. CITY, TOWN OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 10732 Oak Forest Dr.								10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? U.S.A							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary				16b. KIND OF BUSINESS/INDUSTRY V.A. Hospital											
17. FATHER'S NAME (First, Middle, Last) Louis Anderson								18. MOTHER'S NAME (First, Middle, Maiden Surname) Hilma Johnson											
19a. INFORMANT'S NAME (Type/Print) Barbara Clopper								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10732 Oak Forest Dr. Hagerstown, Md. 21740											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematory 2-22-94				20c. LOCATION — City or Town, State Smithsburg, Md.											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Pennis R. Davis								22. NAME AND ADDRESS OF FACILITY Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD with thrombotic vascular disease DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												Approximate interval between Onset and Death Sudden							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA				OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				26. PLACE OF DEATH (Check only one)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER R. L. Kuster MD								29c. LICENSE NUMBER D 26579				29d. DATE SIGNED (Month, Day, Year) 2/21/94							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. L. Kuster MD 100 Gentry Lane, Keadysville, Md 21756																			
31. DATE FILED (Month, Day, Year) FEB 24 1994				32. REGISTRAR'S SIGNATURE John S. Davis															



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				94 06950									
CERTIFICATE OF DEATH				REG. NO.													
1. DECEDENT'S NAME (First, Middle, Last) <u>Joseph English</u> <u>Joseph Francis English</u>				2. DATE OF DEATH MONTH <u>02</u> DAY <u>19</u> YEAR <u>94</u>				3. TIME OF DEATH <u>1:20 AM</u> <u>M</u>									
4. SOCIAL SECURITY NUMBER <u>579 442759</u>		5. SEX <u>1</u> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>86</u> <u>95</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <u>10-14-08</u>		8. BIRTHPLACE (State or Foreign Country) <u>Pennsylvania</u>							
9a. FACILITY NAME (If not institution, give street and number) <u>M.C. Silver Spg, Md. N.H.</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Silver Spg</u>				9c. COUNTY OF DEATH <u>MD</u> <u>20904</u>									
10a. STATE <u>none</u>		10b. COUNTY <u>none</u>		10c. CITY, TOWN OR LOCATION <u>Washington, D.C.</u>				10d. INSIDE CITY LIMITS? <u>1</u> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
10e. STREET AND NUMBER <u>3620 Norton Place, N.W.</u>				10f. ZIP CODE <u>20016</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
11. MARITAL STATUS <u>3</u> <input checked="" type="checkbox"/> Widowed <u>4</u> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> <input type="checkbox"/> YES <u>2</u> <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <u>white</u>									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>5+</u> College (1-4 or 5+) <u>5+</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Lawyer/professor</u>				16b. KIND OF BUSINESS/INDUSTRY <u>law</u>											
17. FATHER'S NAME (First, Middle, Last) <u>Patrick John English</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Catherine Gannon</u>													
19a. INFORMANT'S NAME (Type/Print) <u>Susanne English</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>175 W. 76th St., New York, N.Y. 10023</u>													
20a. METHOD OF DISPOSITION <u>1</u> <input checked="" type="checkbox"/> Burial <u>2</u> <input type="checkbox"/> Cremation <u>3</u> <input type="checkbox"/> Removal from State <u>4</u> <input type="checkbox"/> Donation <u>5</u> <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Gate of Heaven Cemetery Feb. 26, 94 Silver Spring, Md.</u>				20c. LOCATION — City or Town, State											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>James E. B. [Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>DeVol Funeral Home</u> <u>2222 Wisconsin Ave., N.W., Washington, DC 20007</u>													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>Pneumonia</u> b. <u>DUE TO (OR AS A CONSEQUENCE OF):</u> c. <u>DUE TO (OR AS A CONSEQUENCE OF):</u> d. <u>DUE TO (OR AS A CONSEQUENCE OF):</u>								Approximate Interval Between Onset and Death									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Coronary artery Disease</u> <u>Organic Brain Syndrome</u>								24a. WAS AN AUTOPSY PERFORMED? <u>1</u> <input type="checkbox"/> YES <u>2</u> <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <u>1</u> <input type="checkbox"/> YES <u>2</u> <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <u>1</u> <input type="checkbox"/> YES <u>2</u> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <u>1</u> <input type="checkbox"/> Inpatient <u>2</u> <input type="checkbox"/> ER/Outpatient <u>3</u> <input type="checkbox"/> DOA OTHER: <u>4</u> <input checked="" type="checkbox"/> Nursing Home <u>5</u> <input type="checkbox"/> Residence <u>6</u> <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH <u>1</u> <input checked="" type="checkbox"/> Natural <u>5</u> <input type="checkbox"/> Pending Investigation <u>2</u> <input type="checkbox"/> Accident <u>3</u> <input type="checkbox"/> Suicide <u>4</u> <input type="checkbox"/> Homicide <u>6</u> <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <u>1</u> <input type="checkbox"/> YES <u>2</u> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED									
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29a. CERTIFIER (Check only one) <u>1</u> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u> <u>MD</u>		29c. LICENSE NUMBER <u>D25430</u>		29d. DATE SIGNED (Month, Day, Year) <u>2/19/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>John Marschus 14333 Laurel-Parie Rd #307 Laurel, MD 20708</u>																	
31. DATE FILED (Month, Day, Year) <u>FEB 22 1994</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>													





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06951

1. DECEDENT'S NAME (First, Middle, Last) MYRNA IRENE EASTER				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 21, 1994				3. TIME OF DEATH 8:50 P.M.	
4. SOCIAL SECURITY NUMBER 577-28-7226		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
9a. FACILITY NAME (If not institution, give street and number) 1501 OAKVIEW DRIVE				9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING				9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT									
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION SILVER SPRING				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1501 OAKVIEW DRIVE				10f. ZIP CODE 20903		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER				16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) GEORGE H. BACON				18. MOTHER'S NAME (First, Middle, Maiden Surname) EMMA S. DEIHR					
19a. INFORMANT'S NAME (Type/Print) FLETCHER J. EASTER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1501 OAKVIEW DRIVE SILVER SPRING, MARYLAND 20903					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) QUANTICO NATIONAL CEMETERY 2/25		DATE		20c. LOCATION — City or Town, State TRIANGLE, VIRGINIA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Steven D. Stroud				22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Alzheimer's Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate interval between Onset and Death 2 yrs.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus arteriosclerotic heart disease								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Harold W. Daper M.D.				29c. LICENSE NUMBER D02112		29d. DATE SIGNED (Month, Day, Year) 2/22/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HAROLD W. DAPER M.D. 9801 GEORGIA AVE. SILVER SPRING, MD 20902									
31. DATE FILED (Month, Day, Year) FEB 25 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 06952

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN HAGAN FUGATE</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>18</b> YEAR <b>94</b>		3. TIME OF DEATH <b>1:00 PM</b>	
4. SOCIAL SECURITY NUMBER <b>544-03-9490</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-25-1920</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Greater Laurel Beltsville Hospital</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Laurel</b>		8c. COUNTY OF DEATH <b>Prince George's</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Beltsville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>11912 Gordon Avenue</b>				10f. ZIP CODE <b>20705</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12 years</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Engineering Designer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Hagan Fugate</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Martha Holland</b>			
19a. INFORMANT'S NAME (Type/Print) <b>June H. Fugate</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory 2/19/94</b>		20c. LOCATION — City or Town, State <b>Alexandria, Virginia</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald V. Borgwardt</i>				22. NAME AND ADDRESS OF FACILITY <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Respiratory failure</b> DUE TO (OR AS A CONSEQUENCE OF):  b. <b>Lung cancer</b> DUE TO (OR AS A CONSEQUENCE OF):  c. _____ DUE TO (OR AS A CONSEQUENCE OF):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Armstrong MD</i>				29c. LICENSE NUMBER <b>093237</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/18/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Paul Armstrong 18201 Laurel PK. Dr. #102 Laurel, MD 20707</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1041

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

1954

RESEARCH REPORT

NO. 1

(5)

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06953

1. DECEDENT'S NAME (First, Middle, Last) <b>MABLE E. FOREMAN</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>21</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>0405</b> M	
4. SOCIAL SECURITY NUMBER <b>215-14-7577</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH MONTH <b>08</b> DAY <b>13</b> YEAR <b>1918</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Poolesville</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>18700 Jerusalem Church Road</b>				10f. ZIP CODE <b>20837</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+) <b>Domestic</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Domestic</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>John Sims</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marion Hall</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Howard Foreman (Son)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18700 Jerusalem Church Rd., Poolesville, MD 20837</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Elijah Church Cemetery 2/24</b>		20c. LOCATION — City or Town, State <b>Poolesville, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>George R. Snowden</b>				22. NAME AND ADDRESS OF FACILITY <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia Aspiration</b> a. <b>PNEUMONIA Aspiration</b> b. <b>Respiratory Arrest, Acute</b> c. <b>MODERATE SEVERE CEREBRAL ANOXIA</b> d. <b>URSAEPISSIS</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Myocarditis</b> <b>SP BREAST CANCER (R)</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>John Snowden MD</b>				29c. LICENSE NUMBER <b>DO 995 MD</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/21/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Hector Asuncion, MD. 18730 Germantown Road, Germantown MD 20874</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

NOV 14 1964

TO THE DIRECTOR  
OF THE BUREAU OF  
LAND MANAGEMENT  
WASHINGTON, D.C.

FROM: [illegible]  
SUBJECT: [illegible]

DATE: [illegible]  
BY: [illegible]  
[illegible]



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06954

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES L. FRYE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 22, 1994</b>		3. TIME OF DEATH P M <b>2:05 P M</b>	
4. SOCIAL SECURITY NUMBER <b>191-20-5763</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 18, 1927</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>MONTGOMERY GENERAL HOSPITAL</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>OLNEY</b>		8c. COUNTY OF DEATH <b>MONTGOMERY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2601 BEL PRE ROAD</b>				10f. ZIP CODE <b>20906</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (14 or 16+) <b>5+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DISABILITY EXAMINER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>SOCIAL SECURITY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>BENJAMIN A. FRYE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MYRTLE J. LOCKHART</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GRETCHEN L. FRYE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10134 GREENOCK ROAD SILVER SPRING, MARYLAND 20901</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>METROPOLITAN CREMATORY 2/23</b>		20c. LOCATION — City or Town, State <b>ALEXANDRIA, VIRGINIA</b>		22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Timothy J. Campbell</i>				22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Myocardial Infarction</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Arteriosclerotic Cardiovascular Disease</i>						Approximate Interval Between Onset and Death <i>6 Hours</i> <i>6 Hours</i> <i>Year</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Benjamin H. Friedman, MD</i>				29c. LICENSE NUMBER <b>2008381</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/22/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Benjamin H. Friedman, MD 1811 Prince Philip Dr, Oly Md. 20832</i>							
31. DATE FILED (Month, Day, Year) <b>FEB 25 1994</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

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RECEIVED FEB 28 1964

SECTION 100

SECTION 100

FEB 28 1964

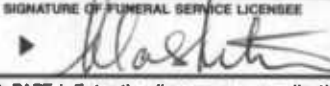
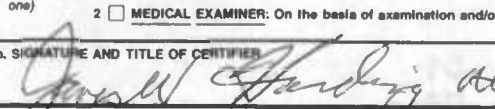
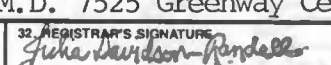


1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06955

1. DECEASED'S NAME (First, Middle, Last) <b>RUTH</b>				2. DATE OF DEATH MONTH <b>FEBRUARY</b> DAY <b>24</b> YEAR <b>1994</b>				3. TIME OF DEATH <b>8:00 AM</b>	
4. SOCIAL SECURITY NUMBER <b>097-09-4588</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MARCH 6, 1906</b>		8. BIRTHPLACE (State or Foreign Country) <b>NEW YORK</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>INDEPENDANCE COURT</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>HYATTSVILLE</b>				9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>	
RESIDENCE OF DECEASED									
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>PRINCE GEORGES</b>		10c. CITY, TOWN OR LOCATION <b>HYATTSVILLE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5821 QUEENS CHAPEL ROAD</b>				10f. ZIP CODE <b>20782</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HOUSEWIFE</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>SAMUEL LEVITT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY FRIEDMAN</b>					
19a. INFORMANT'S NAME (Type/Print) <b>MARTIN FELDMAN (SON)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>116 HAMILTON AVENUE - SILVER SPRING, MARYLAND 20901</b>					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CEDAR PARK CEMETERY</b>		DATE <b>2/27</b>		20c. LOCATION — City or Town, State <b>PARAMUS, NEW JERSEY</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852</b>					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrhythmia, ventricular</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Severe degenerative atherosclerotic heart disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Atherosclerotic cerebrovascular &amp; coronary artery disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Atherosclerotic peripheral disease</b> Approximate Interval Between Onset and Death: <b>minutes</b> , <b>5-7 years</b> , <b>years</b>								23b. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>DO 5401</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/29/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James W. Harding, M.D. 7525 Greenway Center Dr. Greenbelt, MD 20770</b>									
31. DATE FILED (Month, Day, Year) <b>FEB 25 1994</b>				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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2

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06956

1. DECEASED'S NAME (First, Middle, Last) Amy Dawn Gillispie				2. DATE OF DEATH MONTH DAY YEAR February 28, 1994		3. TIME OF DEATH 0200 A M					
4. SOCIAL SECURITY NUMBER N/A		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 27		7. DATE OF BIRTH (Month, Day, Year) Feb. 28, 1994		8. BIRTHPLACE (State or Foreign Country) Frederick			
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Frederick			9c. COUNTY OF DEATH Frederick				
10a. STATE MD		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER 90 Waverly Drive, P-103				10f. ZIP CODE 21702		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A		College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16b. KIND OF BUSINESS/INDUSTRY N/A					
17. FATHER'S NAME (First, Middle, Last) Ronald Lee Gillispie				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bonnie Jean Lowe							
19a. INFORMANT'S NAME (Type/Print) Bonnie Jean Lowe				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Frederick Memorial Hospital			20c. LOCATION — City or Town, State Frederick, MD						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James R. Kull				22. NAME AND ADDRESS OF FACILITY 400 W. 7th St., Frederick, MD 21701							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>PREMATURITY</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>CARDIAC STANDSTILL</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Charles Y. Kim						29c. LICENSE NUMBER D21016		29d. DATE SIGNED (Month, Day, Year) 3/4/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHARLES Y. KIM, MD, 187 THOMAS JOHNSON DR. FREDERICK MD 21702											
31. DATE FILED (Month, Day, Year) MAR 09 1994				32. REGISTRAR'S SIGNATURE Julia Davidson							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06957

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <i>Graham Blake Gordon</i>				2. DATE OF DEATH MONTH DAY YEAR <i>Feb. 24, 1994</i>		3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER <i>237-48-9885</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>60</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Sept. 16, 1933</i>		8. BIRTHPLACE (State or Foreign Country) <i>North Carolina</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>11900 Beavervale Rd.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Smithsburg</i>			9c. COUNTY OF DEATH <i>Washington</i>				
RESIDENCE OF DECEDENT											
10a. STATE <i>Md.</i>		10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Smithsburg</i>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER <i>11900 Beavervale Rd.</i>				10f. ZIP CODE <i>21783</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>Korean Conflict</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (8-12)</i>			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Manager</i>			16b. KIND OF BUSINESS/INDUSTRY <i>Trucking Co.</i>					
17. FATHER'S NAME (First, Middle, Last) <i>Samuel Gordon</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Evelyn Ayers</i>							
19a. INFORMANT'S NAME (Type/Print) <i>Harriet Gordon</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11900 Beavervale Rd. Smithsburg, Md. 21783</i>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Pinnacle U.M. Church Cem. 2-28-94</i>		DATE <i>2-28-94</i>		20c. LOCATION — City or Town, State <i>Pinnacle N.C.</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Rennick L. Davis</i>				22. NAME AND ADDRESS OF FACILITY <i>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Lung Cancer</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. c. d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death <i>3 mth</i>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Pulmonary Disease</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>W.B. Kerns</i>						29c. LICENSE NUMBER <i>D38471</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/25/94</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>William B. Kerns M.D. 22911 Jefferson Blvd Smithsburg, Md. 21783</i>											
31. DATE FILED (Month, Day, Year) <i>MAR 01 1994</i>				32. REGISTRAR'S SIGNATURE <i>Julius Anderson-Randall</i>							

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				94 06958			
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH			
Elizabeth Gordon				2-17-94				11:30 a M			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
505-12-7622		1 M 2 F		78 YRS.		JUNE 29, 1915		ILLINOIS			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
7051 CARROLL AVENUE #403				TAKOMA PARK				MONTGOMERY			
RESIDENCE OF DECEDENT											
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?					
MARYLAND		MONTGOMERY		TAKOMA PARK		1 YES 2 NO					
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
7051 CARROLL AVENUE #403				20912				USA			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.					
1 Never Married 2 Married 3 Widowed 4 Divorced		1 YES 2 NO IF YES, GIVE WAR OR DATES		1 YES 2 NO Specify:		Specify:				WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) 12 College (1-4 or 5 +)				SECURITY OFFICER				U.S. NAVY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
ARTHUR THOMAS				MARY E. VAN NUYS							
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
SUZANNE GORDON				10307 PROCTOR STREET SILVER SPRING, MARYLAND 20901							
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State							
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		METROPOLITAN CREMATORY 2/21		ALEXANDRIA, VA							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY							
Timothy G. Campbell				FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. COR PULMONALE								5 YEARS			
Due to (or as a consequence of):											
b. CHRONIC OBSTRUCTIVE LUNG DISEASE								20 YEARS			
Due to (or as a consequence of):											
c. Due to (or as a consequence of):											
d. Due to (or as a consequence of):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
VALVULAR HEART DISEASE								1 YES 2 NO		1 YES 2 NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)							
1 YES 2 NO				HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. MANNER OF DEATH		28a. DATE OF INJURY		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED			
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		Month, Day, Year		M		1 YES 2 NO					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one)				29b. LICENSE NUMBER				29c. DATE SIGNED (Month, Day, Year)			
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				D 33554				FEB. 18, 1994			
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)			
John E. Yerg, II, M.D.				D 33554				FEB. 18, 1994			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
JOHN E. YERG, II, M.D. 5401 WESTERN AVENUE, N.W. WASHINGTON, D.C. 20015-2998											
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE							
FEB 23 1994				John Davidson-Randall							





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06959

1. DECEDENT'S NAME (First, Middle, Last) <b>DANIEL RAYMOND HALL, SR.</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>24</b> YEAR <b>94</b>		3. TIME OF DEATH <b>5:30 a.m.</b>				
4. SOCIAL SECURITY NUMBER <b>245-22-3064</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 18, 1927</b>		8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Washington County Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>			9c. COUNTY OF DEATH <b>Washington</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Hagerstown</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>18622 Terminal Drive</b>				10f. ZIP CODE <b>21742</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Truck Driver</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Trucking Company</b>					
17. FATHER'S NAME (First, Middle, Last) <b>John Roger Hall</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ethel Mae Hall</b>						
19a. INFORMANT'S NAME (Type/Print) <b>Vicki D. Hall</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18622 Terminal Drive, Hagerstown, Maryland 21742</b>						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rest Haven Cemetery Feb. 26, 1994 Hagerstown, Maryland</b>		20c. LOCATION — City or Town, State						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Douglas A. Fiery</b>				22. NAME AND ADDRESS OF FACILITY <b>Douglas A. Fiery Funeral Home 21742 1331 Eastern Blvd. North Hagerstown, MD</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Ruptured Abdominal Aortic Aneurysm</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Artery Disease</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <b>ILANA ROBBINS MD</b>				29c. LICENSE NUMBER <b>1744471</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/24/94</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>HAGERSTOWN SURGICAL CLINIC 11110 Mcd. Campus DR. Hagerstown MD 21742</b>										
31. DATE FILED (Month, Day, Year) <b>FEB 28 1994</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>						

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REPORT OF THE

COMMISSIONER OF

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1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06960

1. DECEDENT'S NAME (First, Middle, Last) Norman Edgar Henry <b>HENRY</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>23</b> YEAR <b>94</b>		3. TIME OF DEATH <b>0834</b> M	
4. SOCIAL SECURITY NUMBER 214-07-7684		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-22-1919	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. CITY, TOWN OR LOCATION OF DEATH SALISBURY		10. COUNTY OF DEATH WICOMICO	
11. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				12. CITY, TOWN OR LOCATION OF DEATH SALISBURY		13. COUNTY OF DEATH WICOMICO	
14. STATE Maryland		15. COUNTY Dorchester		16. CITY, TOWN OR LOCATION Cambridge		17. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
18. STREET AND NUMBER 308 E. Appleby Avenue				19. ZIP CODE 21613		20. CITIZEN OF WHAT COUNTRY? US	
21. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		22. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		24. RACE — American Indian, Black, White, etc. Specify: White	
25. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>College</b>		26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electronics Co. Employee		27. KIND OF BUSINESS/INDUSTRY			
28. FATHER'S NAME (First, Middle, Last) Norman Edgar Henry				29. MOTHER'S NAME (First, Middle, Maiden Surname) Nettie Mae Sellers			
30. INFORMANT'S NAME (Type/Print) Andrea H. Lane				31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5940 Heritage Rd. East New Market, Md. 21631			
32. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) East New Market Cemetery 2/26		34. LOCATION — City or Town, State East New Market, Md.			
35. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas J. Lomas</i>				36. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust Street Cambridge, Maryland 21613			
37. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Papillary muscle rupture and</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Mitral valve insufficiency</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Acute myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Arteriosclerotic coronary artery disease</i> Approximate Interval Between Onset and Death <i>1 week</i> <i>3 to 4 weeks</i> <i>years?</i>							
38. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 29a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
39. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		40. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
41. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		42. DATE OF INJURY (Month, Day, Year)		43. TIME OF INJURY M		44. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
45. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				46. DESCRIBE HOW INJURY OCCURRED			
47. LOCATION (Street and Number or Rural Route Number, City or Town, State)				48. DATE OF INJURY			
49. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
50. SIGNATURE AND TITLE OF CERTIFIER <i>Michael P. Buchness</i>				51. LICENSE NUMBER 02038		52. DATE SIGNED (Month, Day, Year) 2/23/94	
53. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Michael A. Buchness</i> 201 Pine Bluff Road Suite 25 Salisbury Md. 21801							
54. DATE FILED (Month, Day, Year) FEB 25 '94				55. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NEW YORK

DECEMBER 1964

SECTION 1000

SECTION 1000



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06961

1. DECEDENT'S NAME (First, Middle, Last) <b>Effa M. Horseman</b>				2. DATE OF DEATH MONTH DAY YEAR <b>02/21/1994</b>		3. TIME OF DEATH <b>1:30 p m</b>			
4. SOCIAL SECURITY NUMBER <b>213-74-3400</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>101</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>04/26/1892</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>William Hill Health Care Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cambridge</b>			9c. COUNTY OF DEATH <b>Dorchester</b>		
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Dorchester</b>		10c. CITY, TOWN OR LOCATION <b>Cambridge</b>			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>410 High Street</b>				10f. ZIP CODE <b>21613</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Nurse</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Health Care</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Jay Holliday Murphy</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dora Delaha Murphy</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Katie M. Brerewood</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>403 Phillips Ave., Cambridge, MD. 21613</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MD. Veterans Cemetery 2-24</b>		DATE <b>2-24</b>		20c. LOCATION — City or Town, State <b>Hurlock, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD. 21613</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CHF - CONGESTIVE HEART FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CA Breast Dementia</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D26385</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-22-94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Michael J. Fadden, M.D., 408 Byrn St., Cambridge, MD. 21613</b>									
31. DATE FILED (Month, Day, Year) <b>FEB 25 '94</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06962

1. DECEDENT'S NAME (First, Middle, Last) <b>Frances B. Hoover</b>				2. DATE OF DEATH MONTH <b>Feb</b> DAY <b>16</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>430 A</b>	
4. SOCIAL SECURITY NUMBER <b>220-46-7102</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUG. 9, 1911</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>15311 PINE ORCHARD DRIVE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>15311 PINE ORCHARD DRIVE</b>			
10f. ZIP CODE <b>20906</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SECRETARY</b>		16b. KIND OF BUSINESS/INDUSTRY <b>FEDERAL GOVERNMENT</b>			
17. FATHER'S NAME (First, Middle, Last) <b>CHARLES BAKER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ROSE PORTER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>PAUL C. DENIS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11 WALNUT LANE SELBYVILLE, DELAWARE 19975</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>FORT LINCOLN CEMETERY 2/19</b>		20c. LOCATION — City or Town, State <b>BRENTWOOD, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Andrew J. Cole</b>				22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. End stage COPD</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>						Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>mitral valve prolapse with regurgitation</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature] MD</b>				29c. LICENSE NUMBER <b>D43202</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-16-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>C. Ozanne-Blankford 3305 W. Leisure world Blvd Silver Spring MD 20901</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.




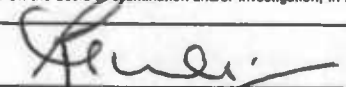
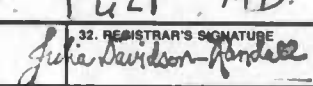


1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06963

1. DECEDENT'S NAME (First, Middle, Last) <b>Margaret K. Holst</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>18</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>1759</b> M	
4. SOCIAL SECURITY NUMBER <b>156-26-1849</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-21-08</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>WASHINGTON ADVENTIST HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TAKOMA PARK</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD.</b>		10b. COUNTY <b>PRINCE GEORGES</b>		10c. CITY, TOWN OR LOCATION <b>MITCHELLVILLE</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>10450 LOTTSFORD RD.</b>				10f. ZIP CODE <b>20721</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>NURSE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>NURSING</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM KIRKHAM</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SUSAN WAGNER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CAROLE F. FISHER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>30 GRACEY RD., CANTON, CONN. 06019</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATED OF DISPOSITION (Name of cemetery, crematory or other place) <b>CHAMBERS CREMATORY</b>		DATE <b>2/21</b>		20c. LOCATION — City or Town, State <b>RIVERDALE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>MO0091</b>				22. NAME AND ADDRESS OF FACILITY <b>W. W. CHAMBERS CO., RIVERDALE, MD. 20737</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Brain lesion</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Primary Cancer Site unknown</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sever Chronic lung disease</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sever Chronic Obstructive lung disease</b> <b>Anaemia</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>NO I/A</b>		28b. TIME OF INJURY <b>NO I/A</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <b>NO I/A</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>NO I/A</b>			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>NO I/A</b>					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D19609</b>		29d. DATE SIGNED (Month, Day, Year) <b>2.19.94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RAMAN. R. TULI MD. 10810 DARNESTOWN RD, GAITHERSBURG, MD</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

General Charles of the 1st Infantry  
Division

1944

1-11-44

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06964

1. DECEDENT'S NAME (First, Middle, Last) <b>HEINRICH WOLFGANG HERZFELD</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB. 18, 1994</b>		3. TIME OF DEATH <b>5:22 A M</b>	
4. SOCIAL SECURITY NUMBER <b>577-52-8828</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec 14, 1914</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Germany</b>				9a. FACILITY NAME (If not institution, give street and number) <b>#1 Denfield Court</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Rockville</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>#1 Denfield Court</b>	
10f. ZIP CODE <b>20851</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>6</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Patent Agent</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Patent Office</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Martin Herzfeld</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Clara Steinbrecher</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Maura L. Herzfeld (Wife)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as #10</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parklawn Cemetery</b>		DATE <b>2-21</b>		20c. LOCATION — City or Town, State <b>Rockville, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> <b>MO0827</b>		22. NAME AND ADDRESS OF FACILITY <b>Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CEREBROVASCULAR ACCIDENT</b> DUE TO (OR AS A CONSEQUENCE OF): <b>HYPERTENSION</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>1 WEEK</b> <b>20 YRS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>METASTATIC PROSTATE CARCINOMA</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>DO7285</b>		29d. DATE SIGNED (Month, Day, Year) <b>Feb. 18, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James A. Brown, M.D. 14808 Physicians Lane #212, Rockville, MD 20850</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06965

1. DECEDENT'S NAME (First, Middle, Last) <i>Bernard H. Horwitz</i>				2. DATE OF DEATH MONTH <i>02</i> DAY <i>22</i> YEAR <i>94</i>				3. TIME OF DEATH <i>1:15 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>215-09-4536</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>89</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>JULY 11, 1904</i>		8. BIRTHPLACE (State or Foreign Country) <i>PA.</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>THE HEBREW HOME</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>ROCKVILLE</i>				9c. COUNTY OF DEATH <i>MONTGOMERY</i>	
10a. STATE <i>MD.</i>		10b. COUNTY <i>MONTGOMERY</i>		10c. CITY, TOWN OR LOCATION <i>ROCKVILLE</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>6121 MONTROSE RD.</i>				10f. ZIP CODE <i>20852</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>SALESMAN</i>				16b. KIND OF BUSINESS/INDUSTRY <i>FURNITURE</i>	
17. FATHER'S NAME (First, Middle, Last) <i>ISAAC HORWITZ</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>HANNAH OSHINSKI</i>					
19a. INFORMANT'S NAME (Type/Print) <i>HERBERT R. HORWITZ</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5004 BARKWOOD PL., ROCKVILLE, MD. 20853</i>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>CHAMBERS CREMATORY 2/24</i>				20c. LOCATION — City or Town, State <i>RIVERDALE, MD.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.W. Chambers</i> MO0091				22. NAME AND ADDRESS OF FACILITY <i>W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Artherosclerotic Heart Disease</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF):  <i>c.</i> DUE TO (OR AS A CONSEQUENCE OF):  <i>d.</i>								Approximate Interval Between Onset and Death <i>years</i> <i>years</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Benign Prostate Hyperplasia</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <i>M</i>				28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lee Jonathan Musher</i>	
29c. LICENSE NUMBER <i>D33357</i>				29d. DATE SIGNED (Month, Day, Year) <i>2/22/94</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Lee Jonathan Musher 1801 E. Jefferson St Rockville MD</i>									
31. DATE FILED (Month, Day, Year) <i>FEB 24 1994</i>				32. REGISTRAR'S SIGNATURE <i>Jelia Davidson-Randall</i>					



94 06966

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gaius Winchester Howe				2. DATE OF DEATH MONTH DAY YEAR February 23, 1994		3. TIME OF DEATH 6:30 P. M.	
4. SOCIAL SECURITY NUMBER 579-32-0020		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 6, 1906	
9a. FACILITY NAME (If not institution, give street and number) 8401 Moorland Lane				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8401 Moorland Lane				10f. ZIP CODE 20817		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Architect		16b. KIND OF BUSINESS/INDUSTRY National Institutes of Health			
17. FATHER'S NAME (First, Middle, Last) Harry Donaldson Howe				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Merriam			
19a. INFORMANT'S NAME (Type/Print) Harry D. Howe				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7637 Normandy Blvd. Indianapolis, Indiana 46278			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Memorial Park 2/26/94		20c. LOCATION — City or Town, State Rockville, Maryland		20d. DATE 2/26/94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Will E. Howe Jr.</i> M00672				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of the Prostate with extensive metastases DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Thrombosis							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augustus A. Aquino</i>				29c. LICENSE NUMBER D02027		29d. DATE SIGNED (Month, Day, Year) February 24, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augustus A. Aquino, M.D. 10401 Old Georgetown Road, Bethesda, Maryland 20814-1911							
31. DATE FILED (Month, Day, Year) FEB 25 1994				32. REGISTRAR'S SIGNATURE <i>John R. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				94 06967							
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH							
Eugene Ray JARVIS				Feb. 23 1994				M							
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
234-42-7190		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		66 YRS.		MONTHS DAYS HOURS MIN.				Feb. 12 1928		West Virginia			
9a. FACILITY NAME (If not institution, give street and number)						9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH					
1049 Glenwood Avenue						Hagerstown				Washington					
RESIDENCE OF DECEDENT												10d. INSIDE CITY LIMITS?			
10a. STATE				10b. COUNTY				10c. CITY, TOWN OR LOCATION				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
Maryland				Washington				Hagerstown							
10e. STREET AND NUMBER						10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?					
1049 Glenwood Avenue						21742				U.S.A.					
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.									
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		Specify: White									
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12) College (1-4 or 5+)				Machinist				Mack Truck							
12															
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAME (First, Middle, Maiden Surname)									
Unknown						Eva Gill									
19a. INFORMANT'S NAME (Type/Print)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Mary Lee Jarvis						1049 Glenwood Avenue Hagerstown, Maryland 21742									
20a. METHOD OF DISPOSITION				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State					
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				Wallace Memorial Cemetery				2-25-94		Clintonville, W.Va.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE						22. NAME AND ADDRESS OF FACILITY									
Scott Minnick						Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												Days			
a. LIVER FAILURE												1/94			
b. EXTENSIVE METASTASIS WITH															
c. MALIGNANT MELANOMA												3/85			
d. MALIGNANT MELANOMA LEFT EYE															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
												1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)											
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA				OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE NOW INJURY OCCURRED					
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one)												29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												D17067		2/24/94	
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER												29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
Fanny Doeta												D17067		2/24/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
STEPHEN METZGER, MD 1825 Hagerstown Rd Hagerstown, MD															
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE											
FEB 24 1994				John Harrison-Pendall											



**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DMMH-18 Rev 1/89



Amended #18, 2/28/94, GAS, Montgomery Co.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06969

1. DECEDENT'S NAME (First, Middle, Last) <b>MARTHA R. JONES</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 22 1994</b>		3. TIME OF DEATH <b>2:20 PM</b>	
4. SOCIAL SECURITY NUMBER <b>085-44-2774 A</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 5, 1911</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Jamaica, West Indies</b>				9. COUNTY OF DEATH <b>Montgomery</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>20419 Lindos Court</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Gaithersburg</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Gaithersburg</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>20419 Lindos Court</b>				10f. ZIP CODE <b>20879</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Jeremiah Myrie</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret (Unknown) Donaldson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Claire Robinson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as #10e.</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rest Haven Cemetery</b>		DATE <b>2/26</b>		20c. LOCATION — City or Town, State <b>Frederick, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Roy W. Barber</i>				22. NAME AND ADDRESS OF FACILITY <b>Muriel H. Barber Funeral Home 20882 21525 Laytonsville Rd., Laytonsville, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Lymphoma</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>6 mo</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D33686</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/29/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Kenneth Miller MD 1811 Prince Philip Dr. Chevy Chase, MD</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 25 1994</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH		REG. NO. 94 06970	
1. DECEDENT'S NAME (First, Middle, Last) <b>ALBERT William KENNEL Jr.</b>				2. DATE OF DEATH MONTH <b>FEBRUARY</b> DAY <b>22</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>6:44 A</b>			
4. SOCIAL SECURITY NUMBER <b>577-44-4467</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>57</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	7. DATE OF BIRTH (Month, Day, Year) <b>Mar. 27, 1936</b>		8. BIRTHPLACE (State or Foreign Country) <b>Washington DC</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CLINTON</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>			
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Clinton</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>10011 Thrift Road</b>				10f. ZIP CODE <b>20735</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sheet Metal Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Albert William Kennel, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Lucille Buckler</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Lillian M. Kennel</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10011 Thrift Rd., Clinton, MD 20735</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Trinity Memorial Gardens</b>		DATE <b>2-25</b>		20c. LOCATION — City or Town, State <b>Waldorf, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Benjamin Matthews M00658</b>				22. NAME AND ADDRESS OF FACILITY <b>Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604-0156</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ADVANCED SQUAMOADENOCARCINOMA OF LEFT LOWER LUNG. MONTHS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. DIFFUSE BONE METASTASIS WEEKS.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. LIVER METASTASIS AND TRANSAMINITIS DAYS.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. HYPERCALCEMIA DAYS.</b>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>BILATERAL PULMONARY INFILTRATES, CACHEXIA DEHYDRATION WITH PERSISTENT NAUSEA AND VOMITING AND GASTRIC ULCER DISEASE,</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Peter W. Yim M.D.</b>		29c. LICENSE NUMBER <b>D12884</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB. 22 1994</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PETER W. YIM M.D. 7900 OLD BRANCH AVE. SUITE 101, CLINTON, MARYLAND 20735</b>									
31. DATE FILED (Month, Day, Year) <b>FEB 25 1994</b>				32. REGISTRAR'S SIGNATURE <b>Juha Davidson-Randall</b>					

23

THE  
OFFICE OF THE  
SECRETARY OF THE  
NAVY  
WASHINGTON, D. C.

TO THE  
HONORABLE  
MEMBERS OF THE  
NAVY  
WASHINGTON, D. C.

THE  
OFFICE OF THE  
SECRETARY OF THE  
NAVY  
WASHINGTON, D. C.

THE  
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WASHINGTON, D. C.

THE  
OFFICE OF THE  
SECRETARY OF THE  
NAVY  
WASHINGTON, D. C.



Kandra, Claire P

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06971

1. DECEDENT'S NAME (First, Middle, Last) <b>CLAIRE PROSSER KANDRA</b>				2. DATE OF DEATH MONTH <b>February</b> DAY <b>19</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>6:05 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>143-18-3457</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 31, 1922</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Montgomery General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Olney</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10e. STREET AND NUMBER <b>3701 International Drive</b>		10f. ZIP CODE <b>20906</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Dietician</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Food Service</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charles Prosser</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mattie Stratton</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gregory Kandra</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3043 14th St., Astoria, New York 11102</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		OATE <b>2/23</b>		20c. LOCATION — City or Town, State <b>Silver Spring, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Roy W. Barber</b>				22. NAME AND ADDRESS OF FACILITY <b>Muriel H. Barber Funeral Home 20882 21525 Laytonsville Rd., Laytonsville, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>BREAST CANCER</b> DUE TO (OR AS A CONSEQUENCE OF): <b>CARDIORESPIRATORY ARREST</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Isabella Martire</b>				29c. LICENSE NUMBER <b>D45014</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/21/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Suite 327, Isabella Martire, M.D. 18111 Prince Phillip Dr, Olney, Maryland 20832</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>				32. REGISTRAR'S SIGNATURE <b>Linda Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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52 NOV 1971

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1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06972

1. DECEDENT'S NAME (First, Middle, Last) ARTHUR LESLIE KENNEY JR				2. DATE OF DEATH MONTH FEB 19 DAY 1994 YEAR		3. TIME OF DEATH 8:40 A M	
4. SOCIAL SECURITY NUMBER 094-14-3758		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) APRIL 1 1923	
8. BIRTHPLACE (State or Foreign Country) MASSACHUSETTS				9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE MARYLAND		10b. COUNTY MONTGOMERY	
10c. CITY, TOWN OR LOCATION ROCKVILLE				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 12513 VILLAGE SQUARE TERRACE #401	
10f. ZIP CODE 20852		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES USPHS WW II	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: CAUCASIAN		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) USPHS - Officer/Physicist	
16b. KIND OF BUSINESS/INDUSTRY Commissioned Corps		17. FATHER'S NAME (First, Middle, Last) ARTHUR LESLIE KENNEY SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZABETH R. WELSH		19a. INFORMANT'S NAME (Type/Print) ARTHUR L. KENNEY III	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600 Ardmore Ave. #411, Hermosa Beach, CA 90254		20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHAMBERS CREMATORY 2/21		20c. LOCATION — City or Town, State RIVERDALE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.W. Chambers</i>		22. NAME AND ADDRESS OF FACILITY MOOO91 W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → RESPIRATORY FAILURE Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. PNEUMONIA c. DUE TO (OR AS A CONSEQUENCE OF): d.		Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeffrey B. Cole MD</i>		29c. LICENSE NUMBER MD D45582		29d. DATE SIGNED (Month, Day, Year) 20 Feb 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JEFFREY B. COLE, LT, MC, USN		31. DATE FILED (Month, Day, Year) FEB 22 1994		32. REGISTRAR'S SIGNATURE <i>John B. ...</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

100-100000-100000

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FOR  
STATE  
1 - REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06973

1. DECEDENT'S NAME (First, Middle, Last) <b>SUSAN A. Kees (SUSAN A. KEES)</b>				2. DATE OF DEATH MONTH DAY YEAR <b>2 27 94</b>		3. TIME OF DEATH <b>1:30 AM</b>	
4. SOCIAL SECURITY NUMBER <b>236-82-9421</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-30-14</b>	
8. BIRTHPLACE (State or Foreign Country) <b>WEST VIRGINIA</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>AVALON MANOR Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>HAGERSTOWN</b>		9c. COUNTY OF DEATH <b>WASHINGTON</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>WV</b>		10b. COUNTY <b>BERKELEY</b>		10c. CITY, TOWN OR LOCATION <b>MARTINSBURG</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>200 E. STEPHEN STREET</b>				10f. ZIP CODE <b>25401</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JAMES WESLEY KEES</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>NANNIE MAE MILLER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. LOUISE BARRETT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RT. 1, BOX 210C, MARTINSBURG, WV 25401</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PRESBYTERIAN CEMETERY</b>		DATE <b>3/1</b>		20c. LOCATION — City or Town, State <b>GERRARDSTOWN, WV</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charles M. Brown</b>				22. NAME AND ADDRESS OF FACILITY <b>BROWN FUNERAL HOME, 327 W. KING ST. POBOX 821, MARTINSBURG, WV 25401</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Cardiopulmonary Failure</b>				Approximate Interval Between Onset and Death <b>2 Hrs.</b>	
		b. <b>Probable Pulmonary Embolism</b>				<b>2 Hrs.</b>	
		c. <b>Fracture Hip</b>				<b>3 weeks</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		d. <b>Congestive Heart Failure</b>				<b>1 yr.</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
e. <b>Senile dementia</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
f. <b>Coronary Artery Disease</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>FEB. 1, 1994</b>		28b. TIME OF INJURY <b>6:30 PM</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT FELL</b>					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>NURSING HOME</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>AVALON MANOR HOME, HAGERSTOWN, MD.</b>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>ZAFAR MAJID MD</b>				29c. LICENSE NUMBER <b>D44996</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-27-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>20311 Lobbans Rd Boonsboro MD 21713</b>							
31. DATE OF DEATH (Month, Day, Year) <b>MAR 0 1994</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician to the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial certificate. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, or cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06974

1. DECEASED'S NAME (First, Middle, Last) <b>Charles Sanford LEONARD</b>				2. DATE OF DEATH MONTH <b>FEB.</b> DAY <b>21</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>0828</b> M	
4. SOCIAL SECURITY NUMBER <b>289-03-5200</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>72</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>July 16, 1921</b>		8. BIRTHPLACE (State or Foreign Country) <b>Ohio</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Washington County Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>		9c. COUNTY OF DEATH <b>Washington</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Hagerstown</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>232 Frederick Street</b>				10f. ZIP CODE <b>21740</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W.II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>route salesman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>dairy</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Sanford Neal Leonard</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Effie Larkins</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Genevieve P. Leonard</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>232 Frederick St., Hagerstown, Maryland 21740</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rest Haven Cemetery</b>		20c. DATE <b>2-24</b>		20d. LOCATION — City or Town, State <b>Hagerstown, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott Minnick</i>				22. NAME AND ADDRESS OF FACILITY <b>MINNICH FUNERAL HOME</b> <b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary arrest</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>Acute Myocardial infarction</b>            DUE TO (OR AS A CONSEQUENCE OF):            DUE TO (OR AS A CONSEQUENCE OF):            DUE TO (OR AS A CONSEQUENCE OF):            DUE TO (OR AS A CONSEQUENCE OF):         </div> <div style="width: 35%; text-align: center;">           Approximate Interval Between Onset and Death  <b>50 minutes</b> </div> </div>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles Sanford Leonard</i>				29c. LICENSE NUMBER <b>D44341</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-21-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ZUBAIR H. FARIDI, MD 249 MILL ST. HAGERSTOWN, MD 21740</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1722

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06975

1. DECEDENT'S NAME (First, Middle, Last) Mary Viola LOWANS		2. DATE OF DEATH MONTH DAY YEAR Feb. 22 1994		3. TIME OF DEATH M
4. SOCIAL SECURITY NUMBER 212-14-7068	5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 73 YRS.	7. DATE OF BIRTH (Month, Day, Year) March 23 1920	
8. BIRTHPLACE (State or Foreign Country) Maryland		9. FACILITY NAME (If not institution, give street and number) 18227 Summerlin Drive		
10. CITY, TOWN OR LOCATION OF DEATH Hagerstown		11. COUNTY OF DEATH Washington		
12. STATE Maryland		13. COUNTY Washington		14. CITY, TOWN OR LOCATION Hagerstown
15. STREET AND NUMBER 18227 Summerlin Drive		16. ZIP CODE 21740		17. CITIZEN OF WHAT COUNTRY? U.S.A.
18. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:
21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		23. KIND OF BUSINESS/INDUSTRY Drug Store
24. FATHER'S NAME (First, Middle, Last) Marshall Richardson		25. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Trace		
26. INFORMANT'S NAME (Type/Print) James S. Mills		27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18227 Summerlin Drive Hagerstown, Maryland 21740		
28. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Lawn Memorial Park 12-26-94 Hagerstown, Maryland		30. LOCATION — City or Town, State
31. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott M. Minnick		32. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PRESUMED MYOCARDIAL INFARCTION b. CEREBRAL VASCULAR DISEASE — c. DIABETES MELLITUS d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28. DATE OF INJURY (Month, Day, Year)		29. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
28. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		29. DESCRIBE HOW INJURY OCCURRED		
29. CERTIFIER (Check only) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER J. D. WOODSTER MD		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		29. LICENSE NUMBER D22043		29d. DATE SIGNED (Month, Day, Year) 2/24/94
31. DATE FILED (Month, Day, Year) FEB 24 1994		32. REGISTRAR'S SIGNATURE John S. Benson-Randall		

*[Faint, illegible handwriting]*

94 06976

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>I. ALAN LOBEL</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 18, 1994</b>				3. TIME OF DEATH <b>11:30 A. M.</b>					
4. SOCIAL SECURITY NUMBER <b>031-28-6865</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>SEPT. 11, 1908</b>		8. BIRTHPLACE (State or Foreign Country) <b>MASSACHUSETTS</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>HEBREW HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ROCKVILLE</b>				9c. COUNTY OF DEATH <b>MONTGOMERY</b>					
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>ROCKVILLE</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>6121 MONTROSE ROAD</b>				10f. ZIP CODE <b>20852</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ATTORNEY</b>		16b. KIND OF BUSINESS/INDUSTRY <b>LAW</b>							
17. FATHER'S NAME (First, Middle, Last) <b>AFCIN LOBEL</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MINNIE GOTTFRIED</b>									
19a. INFORMANT'S NAME (Type/Print) <b>MARTIN LOBEL (SON)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4525 31ST. STREET, N.W. - WASHINGTON, D.C. 20008</b>									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SHARON MEMORIAL PARK</b>		OATE <b>2/20</b>		20c. LOCATION — City or Town, State <b>SHARON MASSACHUSETTS</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Pneumonia</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. Arteriosclerotic cardiovascular disease</b>  c. d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dehydration</b>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D41931</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB. 18, 1994</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R Shumacher MD 3309 Shorefield Rd Wheaton MD 20902</b>													
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>													

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


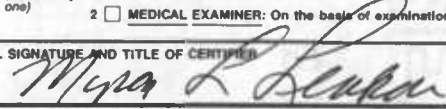
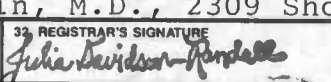


1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06977

1. DECEDENT'S NAME (First, Middle, Last) Dora London				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 17, 1994		3. TIME OF DEATH 6:05 P M	
4. SOCIAL SECURITY NUMBER 577-84-4027		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 19, 1904	
8a. FACILITY NAME (If not institution, give street and number) Potomac Valley Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Potomac		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE D.C.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Washington		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4000 Massachusetts Avenue, NW #1127				10f. ZIP CODE 20016		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMOED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 8+) College (1-4 or 8+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Abe Abrhams				18. MOTHER'S NAME (First, Middle, Maiden Surname) Esther Forman			
19a. INFORMANT'S NAME (Type/Print) Rick M. London				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4000 Massachusetts Avenue, NW #1127 Washington, DC 20016			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery 2/23		DATE 2/23		20c. LOCATION — City or Town, State Arlington, VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Washington, DC 20016			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Acute myocardial infarct</u> DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <u>Sudden</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Arteriosclerotic Cardiovascular Disease</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D06674		29d. DATE SIGNED (Month, Day, Year) 02-18-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Myron L. Lenkin, M.D., 2309 Shorefield Road, Wheaton, MD 20902							
31. DATE FILED (Month, Day, Year) FEB 25 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEVELOPMENTAL

RESEARCH

RESEARCH

RESEARCH

1

94 06978

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Thomas Joseph Larner</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>19</b> YEAR <b>94</b>		3. TIME OF DEATH <b>8:00 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>578-22-0210</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 26, 1924</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Washington, D.C.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>4501 Tonquil Street</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Beltsville</b>	
9c. COUNTY OF DEATH <b>Prince George's</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>	
10c. CITY, TOWN OR LOCATION <b>Beltsville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>4501 Tonquil Street</b>	
10f. ZIP CODE <b>20705</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 years</b> College (1-4 or 5+) <b>4 years</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Technical Writer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N.S.A. U.S. Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Thomas Patrick Larner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Mae Newman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>June S. Larner</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory 2/20/94</b>		DATE <b>2/20/94</b>		20c. LOCATION — City or Town, State <b>Alexandria, Virginia</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Donald V. Borgwardt</b>				22. NAME AND ADDRESS OF FACILITY <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Chronic Obstructive Pulmonary Disease</b> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>1 day</b> <b>Long-standing</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Compression Fractures of Spine (PATHOLOGIC)</b> <b>Arthritis</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. Paul Kretzing</b>				29c. LICENSE NUMBER <b>1721435</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-19-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ira Paul Kretzing MD 2101 Medical Park Dr Silver Spring MD 20910</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

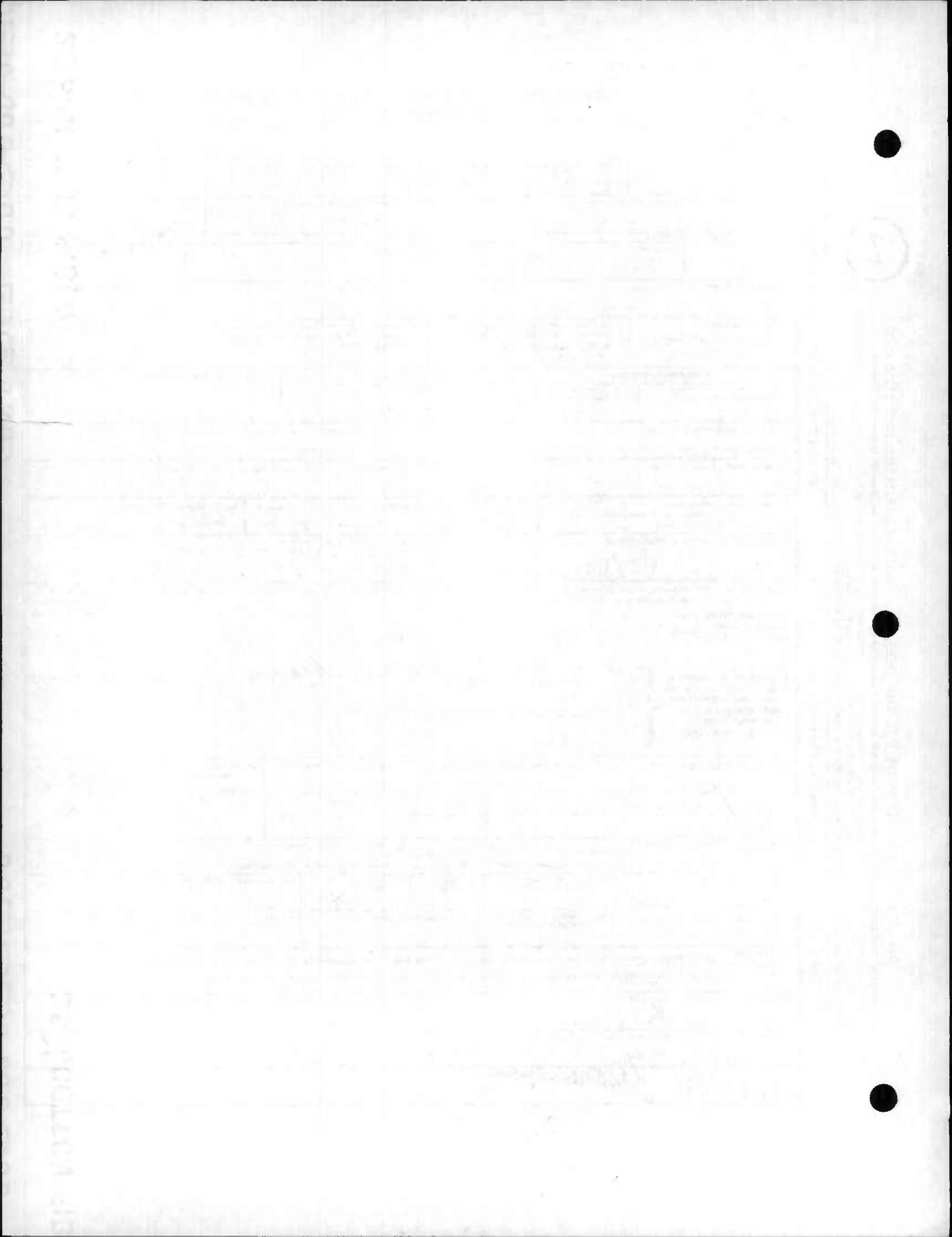
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15+1





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06979

1. DECEDENT'S NAME (First, Middle, Last) <b>CATHERINE M LONG</b>				2. DATE OF DEATH <b>2-20-1994</b>		3. TIME OF DEATH <b>12:00 PM</b>	
4. SOCIAL SECURITY NUMBER <b>578-38-7691</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-24-1921</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Washington Adventist Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Takoma Park</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
RESIDENCE OF DECEDENT							
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Washington, DC</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>815 Tuckerman Street, NW</b>				10f. ZIP CODE <b>20011</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Dozier Wall</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lula Funderburk</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Yvonne Rhodes (Daughter)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>815 Tuckerman St., NW, Wash. DC 20011</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Ma. Nat'l Memorial Pk</b>		DATE <b>2/25</b>		20c. LOCATION — City or Town, State <b>Laurel, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Metastatic Lung Cancer</b>  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>3 months</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>N / R</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sajeev Anand MD</i>				29c. LICENSE NUMBER <b>D-33782</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/22/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Sajeev Anand, MD 7227, B Hanover Pk, Greenbelt, MD 20770</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>		32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-2, 3-8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

EXPLANATION

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

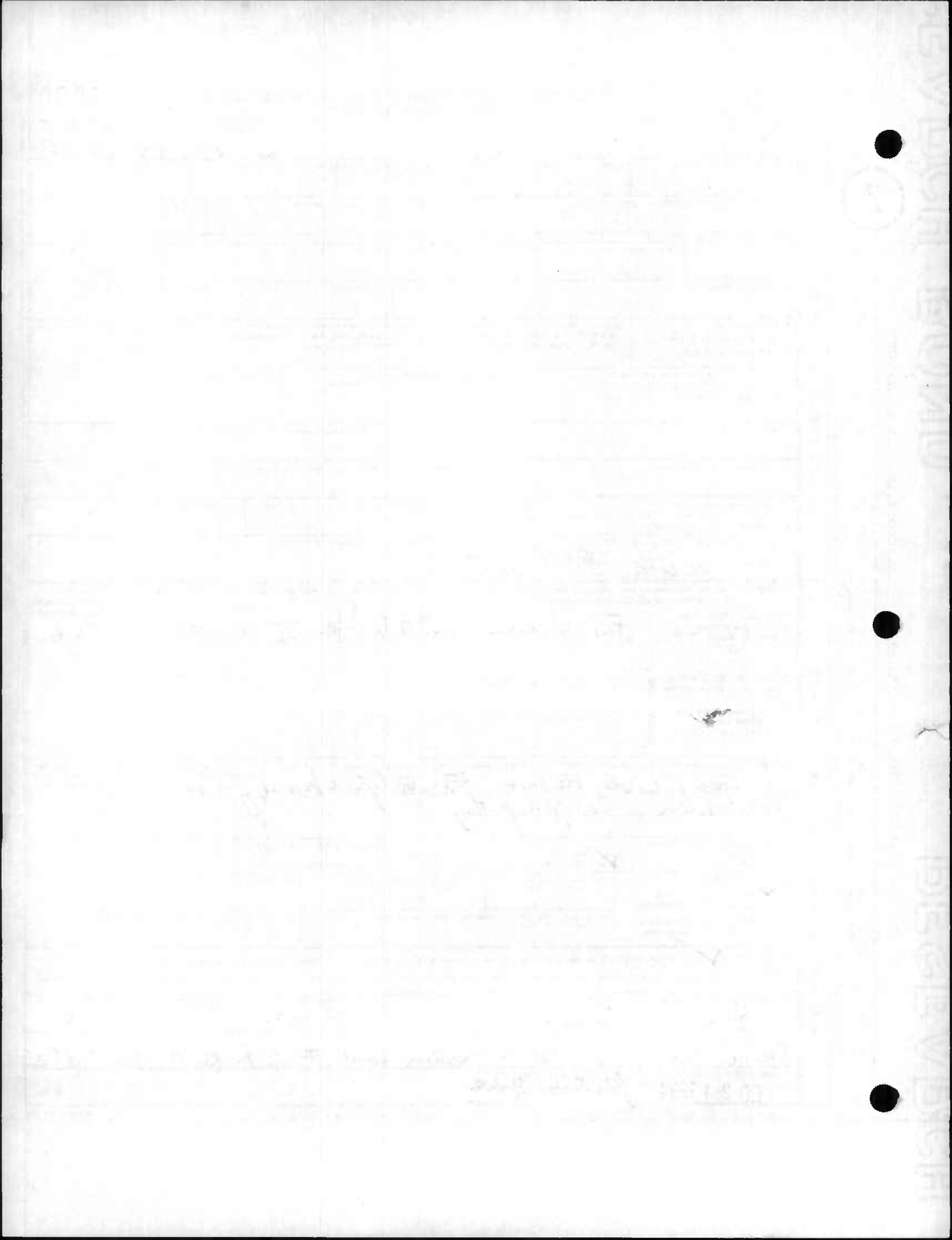
1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06980

1. DECEDENT'S NAME (First, Middle, Last) <b>LOIS A L E NORI</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>19</b> YEAR <b>94</b>		3. TIME OF DEATH <b>20:30</b> M					
4. SOCIAL SECURITY NUMBER <b>579 50 9167</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>51</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 31, 1942</b>		8. BIRTHPLACE (State or Foreign Country) <b>Washington, D.C.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Washington Adventist Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Takoma Park</b>				9c. COUNTY OF DEATH <b>Montgomery</b>			
RESIDENCE OF DECEDENT											
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George</b>		10c. CITY, TOWN OR LOCATION <b>Hyattsville</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>6530 23rd Ave.</b>				10f. ZIP CODE <b>20782</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Accountant</b>			15b. KIND OF BUSINESS/INDUSTRY <b>U.S. Government</b>						
17. FATHER'S NAME (First, Middle, Last) <b>Alfred Alexander</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Christine Smackum</b>							
19a. INFORMANT'S NAME (Type/Print) <b>John H. Lenori</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6530 23rd Ave., Hyattsville, Maryland 20782</b>							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Baltimore Washington Crem.</b>		DATE		20c. LOCATION — City or Town, State <b>Laurel, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harvey E. Huth</i>				22. NAME AND ADDRESS OF FACILITY <b>McGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Wash., D.C. 20012</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Far advanced metastatic breast cancer</b> DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death <b>2 years</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ascites, Liver Failure, Electrolyte abnormality, Anorexia, Coagulopathy</b>								24a. WAS AN AUTOPSY PERFORMED? YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David Kim</i>				29c. LICENSE NUMBER <b>D4007A</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-22-94</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Daniel Kim, M.D. 121 Congressional Lane, #31A, Rockville, MD 20852</b>											
31. DATE FILED (Month, Day, Year) <b>FEB 24 1994</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO. 94 06981							
1. DECEDENT'S NAME (First, Middle, Last) Edward E. Long								2. DATE OF DEATH MONTH DAY YEAR February 22, 1994				3. TIME OF DEATH 5:20 pm M							
4. SOCIAL SECURITY NUMBER 215-16-1782				5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) June 22, 1921		8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Nursing Center								9b. CITY, TOWN OR LOCATION OF DEATH Rockville				9c. COUNTY OF DEATH Montgomery							
10a. STATE Maryland								10b. COUNTY Montgomery				10c. CITY, TOWN OR LOCATION Rockville							
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO																			
10e. STREET AND NUMBER 9801 Watts Branch Drive								10f. ZIP CODE 20850				10g. CITIZEN OF WHAT COUNTRY? United States							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) —				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer				15b. KIND OF BUSINESS/INDUSTRY US Navy											
17. FATHER'S NAME (First, Middle, Last) Edward B. Long								18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Evans											
19a. INFORMANT'S NAME (Type/Print) Helen E. Long								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9801 Watts Branch Drive Rockville, Maryland 20850											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Potomac United Methodist Church Cemetery Potomac, Md. February 25, 1994				20c. LOCATION — City or Town, State											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert A. Pumphrey</i> M00335								22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia a. DUE TO (OR AS A CONSEQUENCE OF): b. Prostatic Cancer c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 2 days 2 years																			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pancytopenia (due to bone marrow metastasis)												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Christopher C. Dunford M.D.</i>								29c. LICENSE NUMBER D 31839				29d. DATE SIGNED (Month, Day, Year) February 23, 1994							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Christopher C. Dunford M.D. 615 West Montgomery Avenue Rockville, Maryland 20850																			
31. DATE FILED (Month, Day, Year) FEB 25 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>															



94 06982

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KATHRYN T. LYNCH</b>				2. DATE OF DEATH MONTH <b>FEB.</b> DAY <b>22</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>0340 AM</b>	
4. SOCIAL SECURITY NUMBER <b>578-09-9918</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>FEB. 10, 1912</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>WASHINGTON ADVENTIST HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TAKOMA PARK</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>PRINCE GEORGES</b>		10c. CITY, TOWN OR LOCATION <b>TAKOMA PARK</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>7004 ASPEN AVENUE</b>			
10f. ZIP CODE <b>20912</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM J. TOOMEY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JULIA LYDON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>PATRICK J. LYNCH, II</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7004 ASPEN AVENUE TAKOMA PARK, MARYLAND 20912</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MOUNT OLIVET CEMETERY</b>		20c. LOCATION — City or Town, State <b>WASHINGTON, D.C.</b>		20d. DATE <b>2/26</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven Stand</i>				22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Dysentery</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Dehydration</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>uncontrolled diabetes mellitus</b> <b>urinary tract infection</b> <b>coronary valvular aortic atherosclerosis</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>2/22/94</b>		28b. TIME OF INJURY <b>4:30 M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. J. J. [Signature] MD MEDICAL DOCTOR</i>				29b. LICENSE NUMBER <b>D 43711</b>		29c. DATE SIGNED (Month, Day, Year) <b>2/22/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>REGINALD D BARNES JR MD 7610 CASHILL AVE, SUITE 310 TAKOMA PARK, MD, 20912</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 25 1994</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



RECEIVED

NOV 19 1964

NOV 19 1964

3



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

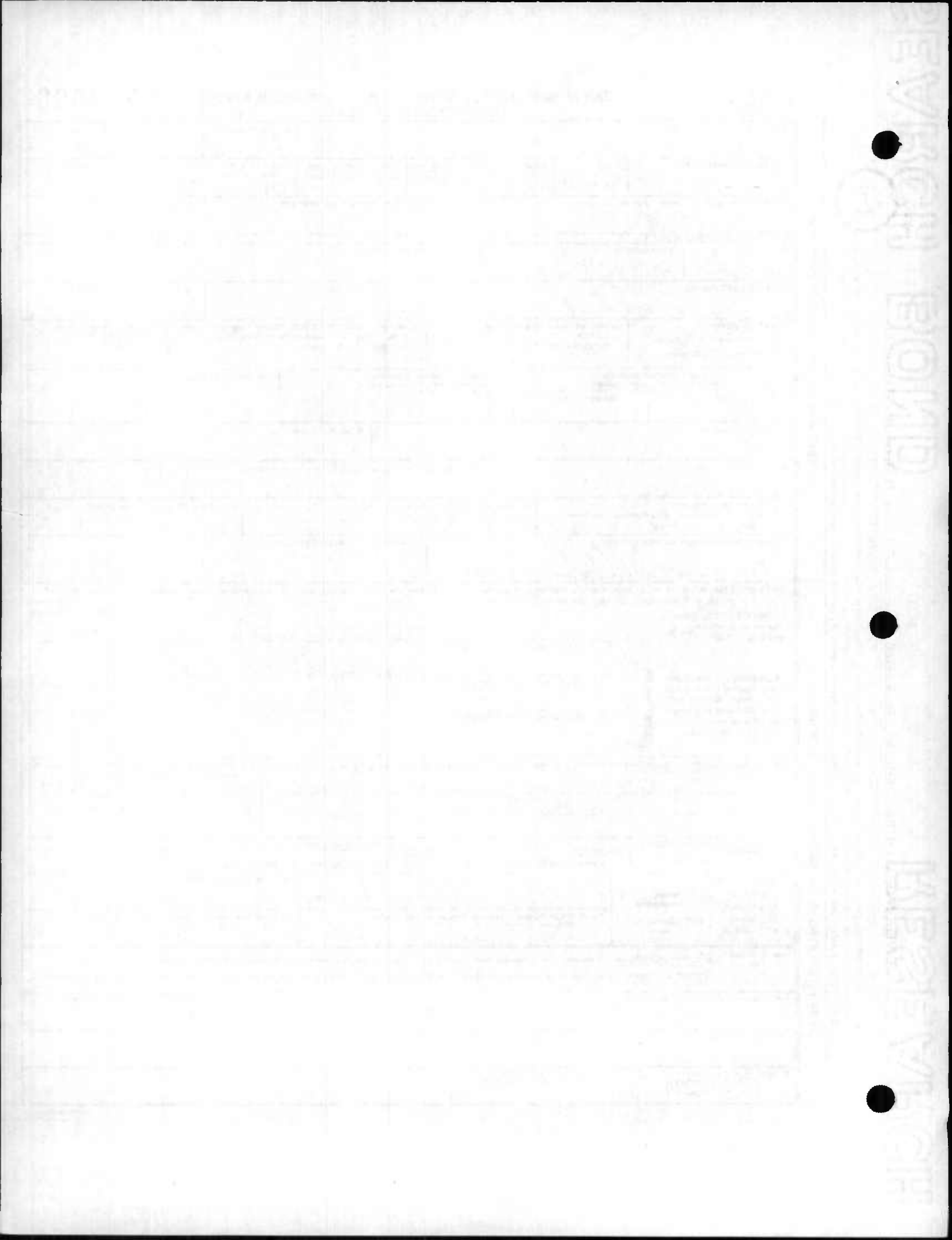
1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06983

1. DECEDENT'S NAME (First, Middle, Last) <b>GEORGE MORRISON</b>				2. DATE OF DEATH MONTH <b>Feb</b> DAY <b>27</b> YEAR <b>94</b>		3. TIME OF DEATH <b>0841 A M</b>					
4. SOCIAL SECURITY NUMBER <b>216-22-9480</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>09/07/27</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not Institution, give street and number) <b>2502 Chestnut Grove Rd.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Sharpsburg</b>			9c. COUNTY OF DEATH <b>Washington</b>				
RESIDENCE OF DECEDENT				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Sharpsburg</b>			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>2502 Chestnut Grove Rd.</b>		10f. ZIP CODE <b>21782</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>owner/operator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Agriculture/Lime</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Harry Morrison</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Viola May Morrison</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Alma L. Morrison</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2502 Chestnut Grove Rd. Sharpsburg, MD 21782</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Samples Manor Cemetery 3/2/94</b>		DATE <b>3/2/94</b>		20c. LOCATION — City or Town, State <b>Dargan, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Osborne Funeral Home P.O. Box 348 Williamsport, MD 21795</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Atherosclerosis, thrombotic vascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Essential Hypertension</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b></b> DUE TO (OR AS A CONSEQUENCE OF): d. <b></b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval Between Onset and Death <b>Sudden</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>gastritis, aortic aortic valve Regurgitation</b> <b>abdominal - Anterior aneurysm.</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>R.L. Kuyler MD</b>						29c. LICENSE NUMBER <b>D26579</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/27/94</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R.L. Kuyler MD 100 Gentry Lane Keedysville, Md 21756</b>											
31. DATE FILED (Month, Day, Year) <b>FEB 28 1994</b>				32. REGISTRAR'S SIGNATURE 							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06984

1. DECEDENT'S NAME (First, Middle, Last) <i>Hunter Wesley Miller</i>				2. DATE OF DEATH MONTH <i>2</i> DAY <i>25</i> YEAR <i>94</i>		3. TIME OF DEATH <i>1600</i> M					
4. SOCIAL SECURITY NUMBER <i>220-10-3092</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>84</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Jan. 8, 1910</i>		8. BIRTHPLACE (State or Foreign Country) <i>Virginia</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>17617 Heisterboro Rd.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown</i>			9c. COUNTY OF DEATH <i>WASHINGTON</i>				
RESIDENCE OF DECEDENT				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Hagerstown</i>			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <i>17617 Heisterboro Rd.</i>		10f. ZIP CODE <i>21740</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Assembler</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Aircraft Manufacturing</i>							
17. FATHER'S NAME (First, Middle, Last) <i>Isaac W. Miller</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Grace Headley</i>							
19a. INFORMANT'S NAME (Type/Print) <i>Martha J. Miller</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>17617 Heisterboro Rd. Hagerstown, MD 21740</i>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Rest Haven Cemetery March 1, 1994</i>		DATE _____		20c. LOCATION — City or Town, State <i>Hagerstown, MD 21740</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>OSBORNE FUNERAL HOME P.O. Box # 348 Williamsport, MD 21795</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Gunshot wound to head</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <i>Suicide</i> b. DUE TO (OR AS A CONSEQUENCE OF): _____ c. DUE TO (OR AS A CONSEQUENCE OF): _____ d. DUE TO (OR AS A CONSEQUENCE OF): _____								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Aneurysm - abdominal aortic</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <i>2/25/94</i>		28b. TIME OF INJURY <i>1600</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED <i>Shot self in head</i>	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>Garage</i>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>17617 Heisterboro Rd Hagerstown</i>					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>D26806</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/25/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <i>Allen W. Dixon 12821 Oak Hill Ave Hagerstown MD 21742</i>											
31. DATE FILED (Month, Day, Year) <i>FEB 28 1994</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06985

1. DECEDENT'S NAME (First, Middle, Last) <i>Larry Dee May</i>				2. DATE OF DEATH MONTH DAY YEAR <i>February 27 1994</i>		3. TIME OF DEATH M <i>1416</i>	
4. SOCIAL SECURITY NUMBER <i>286-30-8335</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>56</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>June 21, 1937</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Ohio</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Washington County Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown</i>	
9c. COUNTY OF DEATH <i>WASHINGTON</i>				10a. STATE <i>Maryland</i>			
10b. COUNTY <i>Washington</i>				10c. CITY, TOWN OR LOCATION <i>Hagerstown</i>			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <i>1732 Edgewood Hill Circle</i>			
10f. ZIP CODE <i>21740</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>1958-1962</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>correction officer</i>		16b. KIND OF BUSINESS/INDUSTRY <i>correctional institute</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Lawrence A. May</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Harriett Landon</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Joyce A. May</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1732 Edgewood Hill Circle, Hagerstown, Md. 21740</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Cedar Lawn Memorial Park 3-2-94 Hagerstown, Maryland</i>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott Minnick</i>				22. NAME AND ADDRESS OF FACILITY <i>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Oat Cell Carcinoma of the lungs</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert B. Buell M.D. Personal Physician</i>				29c. LICENSE NUMBER <i>D04359</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/28/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Robert Buell MD 1459 Potomac Ave Hagerstown</i>				31. DATE FILED (Month, Day, Year) <i>FEB 28 1994</i>			
32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


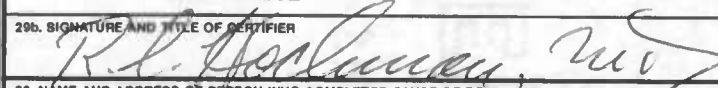
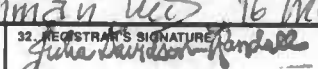
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**IMPORTANT:** If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last) <b>LUCILLE MARKOWITZ</b>		2. DATE OF DEATH MONTH <b>02</b> DAY <b>23</b> YEAR <b>94</b>		3. TIME OF DEATH <b>1300</b>	
4. SOCIAL SECURITY NUMBER <b>12514-0698</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>SEPT. 9, 1926</b>		8. BIRTHPLACE (State or Foreign Country) <b>NEW YORK</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>ANNE ARUNDEL MEDICAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>ANNAPOLIS</b>		9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>	
RESIDENCE OF DECEDENT					
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>ROCKVILLE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>5911 EMPIRE WAY</b>		10f. ZIP CODE <b>20852</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>	
17. FATHER'S NAME (First, Middle, Last) <b>LOUIS BORDEN</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA LIFSCHITZ</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MILTON MARKOWITZ</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5911 EMPIRE WAY - ROCKVILLE, MD. 20852</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>MT. COMFORT CREMATORY</b>		20c. LOCATION — City or Town, State <b>ALEXANDRIA, VIRGINIA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.</b> <b>1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Cancer</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____					Approximate Interval Between Onset and Death <b>2 years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____		26. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
27a. DATE OF INJURY (Month, Day, Year)		27b. TIME OF INJURY <b>M</b>		27c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27d. DESCRIBE HOW INJURY OCCURRED		28a. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)		28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>DD 5192</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/23/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <b>Richard I. Hochman MD 16 Murray Ave, Annapolis, Md 21401</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 25 1994</b>		32. REGISTRAR'S SIGNATURE 			







1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06987

1. DECEDENT'S NAME (First, Middle, Last) <b>Doris Motley</b>		DORIS ELIZABETH MOTLEY		2. DATE OF DEATH MONTH <b>2</b> - DAY <b>20</b> - YEAR <b>94</b>		3. TIME OF DEATH <b>10:45</b> M	
4. SOCIAL SECURITY NUMBER <b>001-22-0165</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUG. 25, 1931</b>	
6. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>		9c. COUNTY OF DEATH <b>Montgomery</b>		8. BIRTHPLACE (State or Foreign Country) <b>NEW HAMPSHIRE</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>GAITHERSBURG</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7546 ELIOAK TERRACE</b>		10f. ZIP CODE <b>20879</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>P.BX. MEDICAL OPERATOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>MONT. COUNTY MEDICAL SOC.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>LAUGHLIN McKENNA</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MINA ROBICHAUD</b>					
19a. INFORMANT'S NAME (Type/Print) <b>KATHRYN M. STEBBINS</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7546 ELIOAK TERRACE GAITHERSBURG, MARYLAND 20879</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GATE OF HEAVEN CEMETERY 2/24</b>		20c. LOCATION — City or Town, State <b>SILVER SPRING, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Timothy J. Canby</b>		22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. BRAIN DEATH</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. HYPOKIL ENCEPHALOPATHY</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. ASTHMA WITH RESPIRATORY ARREST</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>		Approximate Interval Between Onset and Death <b>2 days</b> <b>2 days</b> <b>2 days</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b></b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <b></b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b></b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b></b>	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Carl J. Schoenberg</b>		29c. LICENSE NUMBER <b>D26540</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/22/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Carl J. Schoenberg 16 220 Frederick Rd. Gaithersburg</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 25 1994</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED

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RECEIVED

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06988

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <i>Ernest</i> ERNEST <i>McDuffie</i> McDUFFEE		2. DATE OF DEATH MONTH <i>02</i> - DAY <i>22</i> - YEAR <i>94</i>		3. TIME OF DEATH <i>9:15</i> A M	
4. SOCIAL SECURITY NUMBER 264-28-1958		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.	
7. DATE OF BIRTH (Month, Day, Year) JAN. 9, 1922		8. BIRTHPLACE (State or Foreign Country) FLORIDA			
9a. FACILITY NAME (If not institution, give street and number) HOLY CROSS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION ROCKVILLE	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 4715 MACON ROAD		10f. ZIP CODE 20852	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MECHANICAL ENGINEER	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16. KIND OF BUSINESS/INDUSTRY DEPT. OF NAVY			
17. FATHER'S NAME (First, Middle, Last) WILLIAM THOMAS McDUFFEE		18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH ABIGAIL HUIE			
19a. INFORMANT'S NAME (Type/Print) HARRIET D. McDUFFEE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4715 MACON ROAD, ROCKVILLE, MD 20852			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) PARKLAWN CEMETERY		20c. LOCATION — City or Town, State 2/26 ROCKVILLE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven D. Strand</i>		22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>aspiration pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>recent CVA</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>hours</i> <i>1-2 weeks</i>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>GI bleed</i> <i>hematoma arthritis</i>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>David A. Bloss MD</i>		29c. LICENSE NUMBER D 23911	
29d. DATE SIGNED (Month, Day, Year) 2/22/94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David A. Bloss MD 9410 Old Georgetown Rd. Bethesda, Md. 20814			
31. DATE FILED (Month, Day, Year) FEB 25 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06989

1. DECEDENT'S NAME (First, Middle, Last) <i>Frances E. Martin</i>				2. DATE OF DEATH MONTH <i>Feb</i> - DAY <i>19</i> - YEAR <i>94</i>		3. TIME OF DEATH <i>4:35 P.</i>	
4. SOCIAL SECURITY NUMBER <i>577-40-2722</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>63</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>02-13-1931</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Suburban Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Bethesda</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Potomac</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>7806 Scotland Drive</i>			
10f. ZIP CODE <i>20854</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>7th</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i>		15b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <i>Frank R. Twyman, Sr.</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Wilson</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Preston Martin (Husband)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7806 Scotland Dr., Potomac, MD 20854</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Gate of Heaven Cem. 2/25</i>		20c. LOCATION — City or Town, State <i>Silver Spring, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY <i>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic Heart Disease</i> a. <i>Arteriosclerotic Heart Disease</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetic neuropathy</i>							Approximate Interval Between Onset and Death
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John A. Snowden</i>				29c. LICENSE NUMBER <i>208546</i>		29d. DATE SIGNED (Month, Day, Year) <i>Feb 20 - 94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John A. Snowden 8218 WISCONSIN AVE</i>							
31. DATE FILED (Month, Day, Year) <i>FEB 22 1994</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06990

1. DECEDENT'S NAME (First, Middle, Last) <b>IRENE MURRAY</b>				2. DATE OF DEATH MONTH <b>FEB.</b> DAY <b>15,</b> YEAR <b>1994</b>		3. TIME OF DEATH <b>10:25 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>070-18-6712</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 23, 1923</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>199 ROLLINS AVENUE #418</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>		9c. COUNTY OF DEATH <b>MONT.</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>MONT.</b>		10c. CITY, TOWN OR LOCATION <b>ROCKVILLE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>199 ROLLINS AVENUE #418</b>				10f. ZIP CODE <b>20852</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Claims Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Life Insurance Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Andrew Matsko</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna (Unknown) MARGARET BERES</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Louise Pino</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13407 Queens La., Ft. Washington, MD 20744</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Long Island National Cem. 2/18</b>		20c. LOCATION — City or Town, State <b>Pinelawn, NY</b>		20d. DATE <b>2/18</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael D. Nelson</i>				22. NAME AND ADDRESS OF FACILITY <b>JOS GAWLERS SONS INC. 5130 WI AVE NW WASHINGTON, D.C. 20016</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ira Berger M.D.</i>				29c. LICENSE NUMBER <b>044157</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB. 16, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>IRA BERGER M.D. 809 VIERS MILL ROAD ROCKVILLE, MARYLAND</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 17 1994</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2 and 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06991

1. DECEDENT'S NAME (First, Middle, Last) <b>ALLISON SIDNEY ALLISON MANNING</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 18, 1994</b>		3. TIME OF DEATH <b>2:15 A<sup>M</sup></b>	
4. SOCIAL SECURITY NUMBER <b>263-68-1577</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>49</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 19, 1944</b>	
8. BIRTHPLACE (State or Foreign Country) <b>NEW YORK</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>WHEATON</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>10934 ROCKY MOUNT WAY</b>				10f. ZIP CODE <b>20902</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PSYCHOLOGIST</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>UNKNOWN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>UNKNOWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>PAMELA A. MANNING</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10934 ROCKY MOUNT WAY WHEATON, MARYLAND 20902</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>METROPOLITAN CREMATORY 2/19</b>		20c. LOCATION — City or Town, State <b>ALEXANDRIA, VIRGINIA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Timothy J. Campbell</i>				22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Hypoxia</b>				Approximate Interval Between Onset and Death <b>4 days</b>	
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. <b>Metastatic carcinoma</b>				6 weeks	
		c. <b>adenocarcinoma left lung</b>				3 months	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Hubert J. Alpert, MD</i>				29c. LICENSE NUMBER <b>D 0143</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/18/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>HUBERT J. ALPERT, MD</b>				<b>8630 FENTON ST. STE. 230 SILVER SPRING, MD 20910</b>			
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED FROM

ST. LOUIS, MO.

RECEIVED FROM

1991 33 834

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06992

1. DECEDENT'S NAME (First, Middle, Last) ANGELINE M. MUCCINO				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 17, 1994		3. TIME OF DEATH 9:45 AM	
4. SOCIAL SECURITY NUMBER 169-01-7929		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 27, 1902	
8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA				9a. FACILITY NAME (If not institution, give street and number) 10627 EASTWOOD AVENUE		9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE MARYLAND		10b. COUNTY MONTGOMERY	
10c. CITY, TOWN OR LOCATION SILVER SPRING				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 10627 EASTWOOD AVENUE	
10f. ZIP CODE 20901				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) MATTEO PASQUALE				18. MOTHER'S NAME (First, Middle, Maiden Surname) CARMELA			
19a. INFORMANT'S NAME (Type/Print) ANGELO MUCCINO				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10627 EASTWOOD AVENUE SILVER SPRING, MARYLAND 20901			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GATE OF HEAVEN CEMETERY 2/19		20c. LOCATION — City or Town, State SILVER SPRING, MARYLAND		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Chewy Cole</i>	
22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Stroke</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Atherosclerosis</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus</i>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Hugo G. Graziani</i>		29c. LICENSE NUMBER 008180		29d. DATE SIGNED (Month, Day, Year) 2-17-94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HUGO G. GRAZIANI, M.D. 717 PERSHING DRIVE SILVER SPRING, MARYLAND 20910	
31. DATE FILED (Month, Day, Year) FEB 22 1994		32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06993

1. DECEDENT'S NAME (First, Middle, Last) Becky M. Martinez				2. DATE OF DEATH MONTH DAY YEAR Feb. 10, 1994		3. TIME OF DEATH 04:48 a. m	
4. SOCIAL SECURITY NUMBER None		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs., last birthday) One Hr. YRS.		7. DATE OF BIRTH (Month, Day, Year) 02/10/1994	
8. BIRTHPLACE (State or Foreign Country) MD		9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2107 Glenallan Avenue, #201				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: Salvadorean		14. RACE — American Indian, Black, White, etc. Specify: Hispanic	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) Jose W. Martinez				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sandra E. Chavez			
19a. INFORMANT'S NAME (Type/Print) Jose W. Martinez				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2107 Glenallan Avenue #201 Silver Spring, MD 20906			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Timothy G. Campbell				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., Md. 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiorespiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Perinatal Asphyxia DUE TO (OR AS A CONSEQUENCE OF): c. Questionable Hypoplastic Lungs DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER A.C. Purushothaman M.D.				29c. LICENSE NUMBER D24071		29d. DATE SIGNED (Month, Day, Year) 02/10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A.C. Purushothaman, M.D.; 7600 Carroll Ave.; Takoma Park, MD 20912							
31. DATE FILED (Month, Day, Year) FEB 22 1994							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06994

1. DECEDENT'S NAME (First, Middle, Last) <b>RUBY MOUSE RUBY K. MOUSE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 14, 1994</b>		3. TIME OF DEATH <b>8:55 A M</b>	
4. SOCIAL SECURITY NUMBER <b>217-32-4866</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct 21, 1912</b>	
8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>				9. FACILITY NAME (If not institution, give street and number) <b>Medlantic Manor</b>			
10. CITY, TOWN OR LOCATION OF DEATH <b>(Layhill) Silver Spring</b>				11. COUNTY OF DEATH <b>Montgomery</b>			
12. STATE <b>N. Carolina</b>		13. COUNTY <b>Pitt</b>		14. CITY, TOWN OR LOCATION <b>Ayden</b>		15. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
16. STREET AND NUMBER <b>106 Coward Street</b>				17. ZIP CODE <b>28513</b>		18. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
19. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		20. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		22. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
23. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		24. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>housewife</b>		25. KIND OF BUSINESS/INDUSTRY <b>own home</b>			
26. FATHER'S NAME (First, Middle, Last) <b>Thomas Blainy</b>				27. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sallie Barnes</b>			
28. INFORMANT'S NAME (Type/Print) <b>Lenore Philips</b>				29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>600 New Hampshire Ave, NE Washington, D.C. 20011</b>			
30. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Evergreen Mem. Estates Cem 2/22</b>		32. DATE <b>2/22</b>		33. LOCATION — City or Town, State <b>Grifton, N. Carolina</b>	
34. SIGNATURE OF FUNERAL LICENSEE <i>[Signature]</i>				35. NAME AND ADDRESS OF FACILITY <b>Hines-Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD</b>			
36. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ASCVD</b>						37. Approximate Interval Between Onset and Death <b>20+ yrs</b>	
38. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASCVD</b>							
39. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
40. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						41. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						42. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
43. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		44. HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		45. 28. PLACE OF DEATH (Check only one) 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
46. 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		47. 28a. DATE OF INJURY (Month, Day, Year)		48. 28b. TIME OF INJURY <b>M</b>		49. 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		50. 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		51. 28d. DESCRIBE NOW INJURY OCCURRED			
		52. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
53. 29a. CERTIFIER (Check one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
54. 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD DR. JEFFREY KELMAN		55. 29c. LICENSE NUMBER <b>D20341</b>		56. 29d. DATE SIGNED (Month, Day, Year) <b>2/17/94</b>			
57. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JEFFREY KELMAN 6325 BELCROFT RD, HYATTSVILLE MD 20782</b>							
58. 31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>		59. 32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06995

1. DECEDENT'S NAME (First, Middle, Last) <b>ANGELINA MANDARA</b>		2. DATE OF DEATH Feb 20, 1994 MONTH DAY YEAR		3. TIME OF DEATH 5:40 A M	
4. SOCIAL SECURITY NUMBER <b>215-46-2694</b>	5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>98</b> YRS.	7. DATE OF BIRTH <b>10-02-1895</b> (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country) <b>ITALY</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>CARRIAGE HILL NURSING GR</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Chevy Chase</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>2925 Terrace Dr</b>		10f. ZIP CODE <b>20815</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>HS (12)</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Businesswoman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Liquor Store Owner</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Aelturio Aquilino</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Antoinette Dimiscio</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Frank Salatto</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2 James Spring Ct, Rockville, MD 20850</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery Feb 23</b>		20c. LOCATION — City or Town, State <b>Brentwood, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Aspiration Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Constrictive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>Minutes</b> <b>Days</b> <b>Weeks Months</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b> <b>Atrial Fibrillation</b> <b>Hypothyroidism</b>					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D36046</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/20/94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John J. Merendino Jr MD 5802 NORTOLSON LANE ROCKVILLE MD 20852</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06996

1. DECEASED'S NAME (First, Middle, Last) <b>LOUIS MARCHITELLI</b>				2. DATE OF DEATH MONTH DAY YEAR <b>2-16-94</b>		3. TIME OF DEATH <b>4:20 AM</b>							
4. SOCIAL SECURITY NUMBER <b>577-03-5082</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 29, 1913</b>		8. BIRTHPLACE (State or Foreign Country) <b>Argentina</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Suburban Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>				9c. COUNTY OF DEATH <b>Montgomery</b>					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Bethesda</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>6211 Stoneham Road</b>				10f. ZIP CODE <b>20817</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>							
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>XX</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chef</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Restaurant</b>									
17. FATHER'S NAME (First, Middle, Last) <b>Giuseppi Marchitelli</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Not Available</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Ronald L. Marchitelli</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12 Plum Grove Way, Gaithersburg, Maryland 20878</b>									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery 2/19/94</b>		DATE <b>2/19/94</b>		20c. LOCATION — City or Town, State <b>Silver Spring, MD</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Michael E. Higgins</b>		22. NAME AND ADDRESS OF FACILITY <b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b>		M00846									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MYOCARDIAL INFARCTION</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>TRAPPED LUNG</b> c. <b>MALIGNANT PLEURAL THICKENING</b> d. <b>METASTATIC CARCINOMA OF UNKNOWN PRIMARY</b>								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SEVERE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Irving Mizus</b>		29c. LICENSE NUMBER <b>026571 MD</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/16/94</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>IRVING MIZUS, MD 5413 CEDAR LANE #206C BETHESDA, MD 20814</b>													
31. DATE FILED (Month, Day, Year) <b>FEB 22 1994</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06997

1. DECEDENT'S NAME (First, Middle, Last) Eva R. Mitchell				2. DATE OF DEATH MONTH DAY YEAR February 19, 1994				3. TIME OF DEATH 12 Noon M							
4. SOCIAL SECURITY NUMBER 577-30-9053				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 2, 1906		8. BIRTHPLACE (State or Foreign Country) Iowa					
9a. FACILITY NAME (If not institution, give street and number) Collingswood Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Rockville				9c. COUNTY OF DEATH Montgomery							
RESIDENCE OF DECEDENT															
10a. STATE Maryland				10b. COUNTY Montgomery				10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 14205 Marian Drive						10f. ZIP CODE 20850			10g. CITIZEN OF WHAT COUNTRY? United States						
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) —				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary				16b. KIND OF BUSINESS/INDUSTRY H.E.W.							
17. FATHER'S NAME (First, Middle, Last) Oscar B. Reberholt						18. MOTHER'S NAME (First, Middle, Maiden Surname) Hansine Christianson									
19a. INFORMANT'S NAME (Type/Print) Ann R. Cooper						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14205 Marian Drive, Rockville, Maryland 20850									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. 2/21/94 DATE				20c. LOCATION — City or Town, State Bethesda, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Nicholas P. Latta</i> M00348				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave. Rockville, Maryland 20850-2805											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Dehydration DUE TO (OR AS A CONSEQUENCE OF):															
b. Urinary Tract Infection DUE TO (OR AS A CONSEQUENCE OF):															
c. DUE TO (OR AS A CONSEQUENCE OF):															
d. DUE TO (OR AS A CONSEQUENCE OF):															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hip Fracture, Alzheimers Disease												24a. WAS AN AUTOPSY PERFORMED? XX YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John S. Samuels S. HANJURA</i>						29c. LICENSE NUMBER 10493			29d. DATE SIGNED (Month, Day, Year) 2/20/94						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VSSaia; 809 Queens Mill Rd Rockville MD 20850															
31. DATE FILED (Month, Day, Year) FEB 22 1994				32. REGISTRAR'S SIGNATURE <i>Jill Davidson-Hendell</i>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.









1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 06999

1. DECEDENT'S NAME (First, Middle, Last) <b>Eddy Jordan Moore</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb 18, 1994</b>		3. TIME OF DEATH <b>8:01 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>427-48-8663</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>60</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 26, 1933</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Mississippi</b>				9a. FACILITY NAME (If not institution, give street and number) <b>9465 Chadburn Place</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Gaithersburg</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Gaithersburg</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>9465 Chadburn Place</b>	
10f. ZIP CODE <b>20879</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>UNKNOWN DATES</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (8-12)</b> <b>12</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Senior System Analyst</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Computer Industry</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Edd Moore</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lillie Mae Jordan</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Betty Winningham</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt. 3, Box 215, Carriere, Mississippi 39426</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hickory Grove</b>		20c. LOCATION — City or Town, State <b>Laurel, Mississippi</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>De Vol Funeral Home</b> <b>10 E. Deer Park Dr., Gaithersburg, MD 20877</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Gunshot of head.</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d.</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>24a. WAS AN AUTOPSY PERFORMED?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  <b>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				25. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Friends House</b>			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>208546</b>		29d. DATE SIGNED (Month, Day, Year) <b>Feb 18-94</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John [illegible] 3218 Wisconsin Ave Bethesda Md</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 23 1994</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

94 07000

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) Florence M. McJames		2. DATE OF DEATH MONTH DAY YEAR Feb. 21 1994		3. TIME OF DEATH 1:30 P M	
4. SOCIAL SECURITY NUMBER 105-05-1382		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 104 YRS.	
7. DATE OF BIRTH (Month, Day, Year) Nov. 4, 1889		8. BIRTHPLACE (State or Foreign Country) New York		9. FACILITY NAME (If not institution, give street and number) 4740 Bradley Blvd.	
10a. STATE MD		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 4740 Bradley Blvd.		10f. ZIP CODE 20814	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home		17. FATHER'S NAME (First, Middle, Last) Charles Sebeck	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Caroline Schroeder		19a. INFORMANT'S NAME (Type/Print) Helen M. Hill		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4740 Bradley Blvd., Bethesda, MD 20814	
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenwood Cemetery 2/23		20c. LOCATION — City or Town, State Brooklyn, NY	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael E. Nelson		22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. NW, Washington, DC 20016		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. cerebral vascular accident b. cerebral arteriosclerosis c. d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  arteriosclerosis arteriosclerotic heart disease	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Wilfred R. Ehrmantaut MD		29c. LICENSE NUMBER D 00946	
29d. DATE SIGNED (Month, Day, Year) Feb. 22, 1994		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Wilfred R. Ehrmantaut, M.D. 11125 Rockville Pike # Rockville, MD 20852-3179		31. DATE FILED (Month, Day, Year) FEB 23 1994	

